Guild Care

Linfield House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 6 and 8 December 2016 and was unannounced.

The last inspection took place in September 2015. As a result of this inspection, we found the provider in breach of four regulations relating to staffing, dignity and respect, good governance and person-centred care. We asked them to submit an action plan on how they would address these breaches. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found that the provider and registered manager had taken appropriate action and all these regulations had been met. As a result, the overall rating for the service has improved from 'Requires Improvement' to 'Good'.

Linfield House is a purpose-built home that provides nursing and personal care for up to 54 people with a variety of health and care needs, including people living with dementia. At the time of our inspection, 53 people were in residence. The home is divided into five units or suites: Richmond suite caters for people living with dementia and is a secure unit. The other four suites provide nursing or residential care: Whitcomb, Frazer, Selden and Gordon. People living in the Richmond suite have separate facilities comprising a sitting room, dining room and have access to a garden. The other suites are housed on the first and second floors at Linfield House. Each suite has its own small lounge, kitchenette area and bathroom. There is a communal lounge and large dining room on the ground floor and a further dining room on the first floor. All rooms have en-suite facilities, including a shower. There are accessible gardens at the rear of the property which overlooks Victoria Park. The home is situated close to the town centre of Worthing.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staffing levels were sufficient to meet people's care needs safely. Staff were used flexibly and could be deployed to areas of the home where additional staffing was required. Improved staffing levels meant that staff had time to spend with people and call bells could be responded to promptly. Safe recruitment practices were in place and people were protected from the risk of abuse and avoidable harm. Staff had been trained in safeguarding adults at risk and knew what action to take in the event they suspected abuse was taking place. Risks to people had been identified, assessed and managed appropriately, with clear guidance for staff on how to mitigate risks. Generally, medicines were managed safely.

People were looked after and supported by kind and caring staff. They were treated with dignity and respect and had the privacy they needed. People were supported to express their views and to be involved in reviewing their care plans. Relatives confirmed they were involved in reviewing their family members' care plans and invited to monthly meetings. Staff knew people well, their likes, dislikes and preferences and positive, caring relationships had been developed. Staff were very attentive to people, were complimentary

on their appearance and genuinely cared about their welfare.

Records containing confidential information about people were kept securely. A range of systems had been put in place to measure and monitor the quality of care delivered and the service overall. Where improvements were identified, actions were taken to address these. People and their relatives were invited to monthly meetings to give their feedback about the service. A survey was sent out in June 2016 to obtain people's feedback and suggestions for any improvements. Staff felt supported by the management team and good leadership was evident. People spoke positively about the care at Linfield House and of the staff who worked there.

Staff were trained in a range of areas and new staff followed the Care Certificate, a universally recognised qualification. The majority of staff had regular supervision meetings. Some staff had not received supervision meetings on a regular basis and the registered manager was taking action to address this. Staff attended monthly team meetings. People's consent was sought in line with the requirements of legislation under the Mental Capacity Act 2005 and staff understood their responsibilities in this area. The majority of people were subject to Deprivation of Liberty Safeguards and applications had been sent to the local authority to seek authorisation. People had sufficient to eat and drink and were encouraged to maintain a balanced diet. People had access to a range of healthcare professionals and support. The environment had been adapted to meet the individual needs of people in residence, especially those living with dementia.

Advice had been sought from healthcare professionals and improvements had been made to the activities on offer. Activities were planned based on people's individual interests and preferences. Staff were flexible in their approach in engaging people with activities and organised group and 1:1 sessions with people. Memory boxes were in the process of being made up for people living with dementia and provided mental stimulation and ideas for conversation. Care plans provided detailed information about people and their support needs, with advice and guidance to staff on how to deliver personalised care. Handover meetings held between shifts enabled staff to receive updates about people and their most up to date care needs. Complaints were managed in line with the provider's policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient to meet people's needs.

People's risks were identified, assessed and managed appropriately. Staff had been trained in safeguarding and knew what action to take if they suspected abuse had taken place.

Generally, medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had completed training in a range of areas and attended team meetings. Some supervisions were not up to date, but the registered manager was taking steps to address this.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had sufficient to eat and drink and were supported by a range of healthcare professionals and services.

The environment had been adapted to meet the needs of people, especially those living with dementia.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in decisions about their care and were involved in review meetings.

People were treated with dignity and respect and afforded the privacy they needed.

Staff were kind, warm, patient and friendly with people. Positive, caring relationships were evident.

Is the service responsive?

Good

The service was responsive.

Activities were organised based on people's interests and hobbies. Activities were planned for small or large groups of people and staff had time to spend with people on a 1:1 basis.

Care plans provided detailed information about people and their support needs.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

Improvements had been made with regard to the secure storage of confidential records and in auditing. Systems were now in place to effectively monitor and measure the service and identify any improvements that were needed.

People and their relatives spoke highly of the care delivered at Linfield House. Meetings were held, and surveys completed, to obtain feedback about the service. Staff felt supported by the management team.

Linfield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 6 and 8 December 2016 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Due to technical issues at the Commission, the provider was unable to complete the PIR as requested. However, they did provide us with information about the service in lieu of a PIR. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including six care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection, we asked for feedback from three healthcare professionals who have involvement with the service. They have given their permission for their comments to be included in this report.

On the day of our inspection, we met with five people living at the service and spoke with seven relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy managers, two registered nurses, a senior care assistant and

four care staff.

Good

Is the service safe?

Our findings

At the inspection in September 2015, we found the provider was in breach of a Regulation associated with safe care and treatment. We asked the provider to take action because staffing levels had not been assessed or monitored to ensure they were sufficient to meet people's needs. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

At the time of our inspection, four or five care staff were on duty in the Richmond suite, with two care staff on duty in each of the other four suites. There were three additional care staff who were 'floaters' and could be deployed flexibly during the day, as people's needs dictated. Two registered nurses provided nursing care on the first and second floors, with a senior team leader in the Richmond suite. At night, five care staff were on duty who were supported by a senior team leader and one registered nurse. At the time of our inspection, 53 people were in residence. The deputy manager advised us that staffing levels in the Richmond suite were calculated based on people's support needs and dependency levels. They explained that four or five care staff (including a senior team leader) would be available in the morning, but this was, "Unpredictable and variable", so staff were used flexibly. On one morning a week, the two senior team leaders allocated to the Richmond suite worked together, which allowed for a face-to-face catch-up meeting and time for administration tasks. We looked at four weeks' rotas which confirmed that staffing levels were consistent across the time examined. Guild Care operates a centralised rota system which enables staffing levels to be maintained within safe limits and staff can volunteer to work across the provider's other homes, if needed.

We asked relatives for their views about staffing. One relative said, "Last year's inspection was about staff shortages and the high use of agency staff. That was a big issue then. Now it's very rare I see agency staff. Things have changed a lot here". The relative added that call bells were responded to promptly. In the Richmond suite, we observed one person appeared to need the toilet and there was just one staff member in the lounge. The person had to wait for a few minutes until another staff member came into the lounge. A relative, who was also present, told us that it was really unusual for people to have to wait to be attended to. They also commented that at weekends, if they came to visit, it could take a while for the front door to be answered and that it was usually staff from the Richmond suite who came to the door and let visitors in.

Staff were positive about the improvement to staffing levels. One staff member explained, "Our staffing levels are really good. I started just after the last inspection. I try and help to relieve pressure from other staff and if I can do something to help with this, I will". Another member of staff was working as a 'floating' member of staff during the afternoon of our inspection and was busy arranging for drinks to be served to people. The registered manager told us that staff breaks were staggered, thus ensuring there were always sufficient numbers of staff working on the floor at any one time. The registered manager added that the increase in staffing levels since our last inspection hade made a positive difference in that staff had time to spend with people and engage in activities. We observed that people's call bells were responded to promptly by staff.

The registered manager told us that, since our last inspection, several new staff had been recruited to work in a caring capacity at Linfield House. A relative said, "They've dealt with the staffing issues very well. They [senior management] invited us to a meeting to tell us what they were doing". Another relative commented that less agency staff were needed since the recruitment of new staff within the last year. Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people.

People were protected from abuse and avoidable harm. We asked people if they felt safe living at Linfield House. One person confirmed they were and added, "I'm quite happy to stay here". A relative referred to their family member and said, "I have total confidence she is safe". We asked staff about their understanding of keeping people safe and what action they would take if they suspected people were at risk. One member of staff said, "You've got to keep your eyes open. I would tell the person in charge if I was concerned. If there was no response, I would go and follow it up". Whilst this member of staff did not tell us directly about reporting any concerns to the local safeguarding authority, they said they would look up who to contact on the internet and would also contact the Commission. They added, "I've never had any concerns". Another member of staff explained their understanding of safeguarding and said, "It's basically making sure residents feel safe in their home and environment and reporting any abuse". They went on to give examples of abuse such as physical, emotional, neglect, institutional and financial. The training matrix confirmed that staff had completed training in safeguarding adults at risk.

Risks to people and the service were managed so people were protected and their freedom was supported and respected. A relative told us about a fall their family member had sustained. They said that night staff would 'floor walk' and regularly monitored people. They said the registered nurse telephoned them promptly to let them know what had happened and the action that had been taken. Another relative commented saying, "Yes, she's completely safe. She's had no falls. She walks with a frame, but she doesn't walk very much. They know what she's like". Care plans showed that people's risks had been identified and assessed and information was provided to staff on how to mitigate risks. For example, in one care plan, risk assessments had been completed in relation to evacuation of the building in an emergency in a Personal Emergency Evacuation Plan, moving and handling, bed rails, falls and skin integrity.

A healthcare professional stated, 'We have not observed any unsafe practices. Whilst we were on the unit, the staff were always aware of residents' whereabouts and any possible safety issues. On one occasion, the team leader responded very promptly to a concern that the main door to Richmond Unit was faulty and that she was very timely in seeking maintenance assistance. People visiting the unit are always asked to identify themselves and the reason for their visit'.

Accidents and incidents were recorded and the log showed the detail of the accident or incident, any injury, whether first aid was administered, any medical treatment required and the subsequent action taken. In addition, there was information about how any reoccurrence of a similar event might be prevented and any emerging patterns or trends. For example, one person had a history of falls and an application was made to the continuing healthcare team for additional funding to provide extra staffing and support. In another person's care plan, their risk assessment for falls noted that they had one or more falls in the last three months and the risk was judged as 'medium'. The assessment advised staff to, 'Remind [named person] to use walking aid at all times' and the risk assessment was due for review in January 2017 or if the person sustained another fall. We observed that people's risks were discussed during a handover meeting which we observed at inspection. One person had developed pressure areas on their heels and a pressure mattress was now needed. A member of staff immediately left the handover meeting to source the relevant

equipment required.

Generally, medicines were managed safely. We observed medicines being administered by an agency registered nurse on the first morning of our inspection. The medicines trolley was locked when the agency nurse left it to administer one person's medicines in their room. However, we observed a plastic box containing eyedrops was on top of the trolley when it was left unattended in the corridor. The registered manager also saw this and said they would deal with the incident and talk to the member of staff concerned. We observed other medicines being administered during the course of our inspection and that these were administered safely by the nursing staff. We observed one member of staff administering medicines in the Richmond suite and they offered the person a choice of apple juice or water to help them swallow their medicine. The member of staff was patient and reassuring and said to the person, "Shall I tip them [tablets] out on to your tray?". It took at least 20 minutes for the person to take their medicines, but the staff member waited patiently with the person to ensure they had taken all their medicines as prescribed.

We checked stocks and storage of medicines in a medicines room and a medicines cupboard in the home. We observed that the temperature of the medicines cupboard in Whitcomb suite was quite warm and the room thermometer showed a reading of between 25 – 26 degrees Celsius. Advice from the Royal Pharmaceutical Society of Great Britain in 'The handling of medicines in social care' states that temperatures in excess of 25 degrees Celsius are too hot for the storage of medicines. The provider's own policy, 'Safe administration of medication policy for care homes' stated, 'Maximum room temperature for storage of medicines is 25c'.We discussed this with the registered manager who stated they would take action to resolve the issue to ensure that the temperature of the medicines cupboard was maintained within safe limits. Medication audits were completed monthly and included competency checks to ensure staff were regularly monitored in the administration of medicines.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Two healthcare professionals stated, 'Three of the care staff that we have worked with are beginning to develop a role as Dementia Leads and one of these staff has been active in further developing a person-centred PowerPoint presentation that she now feels confident to support staff with'.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. We spoke with a member of staff who had come to work at Linfield House in recent months. They explained they had completed an induction programme and they had found the training, "Very informative". They told us they were still in the process of completing all essential training and had completed training in moving and handling, person-centred care and dementia awareness. They said, "I've also been doing the dementia workshops too; it's all very good and informative". Another member of care staff talked about their induction and said, "It was very good and I was introduced to everyone; that was really nice!". A third member of staff said, "There is always something to learn and what is wonderful is that Guild Care provide that. I'm very happy with the training". We examined the staff training plan which showed that staff had completed training in a range of areas, including health and safety, fire safety, basic first aid, moving and handling, safeguarding, infection control, food safety, dementia, mental health, mental capacity and some staff had completed medication awareness. Areas such as moving and handling, fire safety, safeguarding and infection control were subject to annual updates. We asked the registered manager whether staff completed training in challenging behaviour. They told us that they had looked into this, but the training on offer was not suitable to meet the needs of people living at Linfield House; appropriate training was being explored.

We asked the registered manager how frequently staff received supervision meetings and were told these occurred three times a year with an annual appraisal. One member of staff told us about their supervision meetings and said, "We talk about anything really. If you're unhappy, you need to say something". We looked at the staff supervision matrix which showed that not all staff had received supervision with this regularity. We asked the registered manager to look into this and we received their response following inspection. The registered manager stated that the supervision matrix had not been updated and that the majority of staff had completed supervision meetings as needed. However, the registered manager had also identified that 14 members of staff had not received supervision recently and stated they would speak to the supervisors to ensure these were updated. Staff supervisions had also been identified as an 'improvement action' in the provider's audit in March 2016. This stated, 'To implement a quarterly supervision structure so that all staff receive regular supervision. All outstanding supervisions to be completed by next inspection. Supervisions have slipped and last quarter's supervision has not been completed'.

Staff meetings were generally held on a monthly basis and records confirmed this. Separate meetings were held for nursing staff, housekeeping staff, day care staff and night care staff. A member of staff confirmed there were staff meetings for the whole home and these were held monthly. They commented, "It is a

chance to discuss any problems. They ask if we have any concerns. They listen to us. I feel confident in speaking to the management". The registered manager felt that the biggest challenge within the last year had been staffing with staff who had worked at the home for a long time being able to accept change and new ways of working. The registered manager told us, "If my staff are happy, the residents are happy".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had completed training on mental capacity and understood their responsibilities under this legislation. One member of staff explained mental capacity as, "About people making their own decisions and helping them. We might need to make a decision in their best interests for them". Another member of staff told us, "Not all people can make decisions for themselves. If they can't make a decision, we have to help them in their best interest to keep them safe and secure". This member of staff understood the need to consult relatives and care professionals in this. We observed that people were involved in making day-to-day decisions and their consent was sought by staff who supported them. For example, we observed two staff hoist one person and this was done safely and their dignity was maintained throughout. The staff explained the process of what they were doing, checked for the person's agreement and talked with them as the hoisting process was completed. They also explained to the person's husband, who was sat next to her, what they were about to do and where they were taking his wife.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS had been submitted to the local authority for the majority of residents at home. These were still being processed by the local authority. One person told us they were free to come and go, but they were unable to go out independently due to issues with their mobility. They said, "They give you a fair bit of freedom, but you have to conform to the rules here. I tell them what I think!". Each suite was secure and staff had fobs which enabled them to enter and exit each suite freely. Visitors needed to ask staff to be let in.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. An outside catering company supplied meals, but all food was cooked on site, with the main meal of the day served at lunchtime. We asked people what they thought about the meals on offer. One person said, "Food is a bit on the stodgy side for me, too many potatoes, but it's cheap". Another person felt, "Food's very good; I expect good food. It's meat and vegetables basically and fruit". A third person said, "Food's lovely generally, but not so appetising sometimes". A relative told us, "I think the food is very good. It's more institutional food than hotel food. Mum sits in the dining room. We've eaten with her and friends can visit whenever". We observed people sitting in the main dining room to have their lunch. Tables were laid nicely and people were offered a choice of drinks. People were shown the food available, which on the first day of our inspection was a choice of steamed fish or chicken curry. One person stated they did not want rice with their curry, so was offered potato instead. The lunchtime meal was a social occasion and people appeared to enjoy their food and were chatting with staff and people sat at their table. A choice of dessert was also offered, either rice pudding or stewed fruit with custard or ice-cream. There were sufficient staff on duty to support people with their meals as needed. Generally, drinks were freely available to people, however, we observed there was no water in the dining room on Frazer suite. The agency nurse, who was administering medicines to people at lunchtime, had to ask for water to be brought in, to enable people to swallow their tablets. We brought this to the attention of the registered manager during feedback at the end of our inspection.

We observed people having their lunch in the Richmond suite on the second day of our inspection. People were asked if they would like to eat in the dining room or in their bedrooms. A choice of three juices was on offer and visual choice was given to people as they were shown each carton. Staff offered people clothes protectors and then checked with people that they were happy to put them on. People were shown the lunchtime meals and people were engaged in expressing their preference, either pointing or looking at the meal they preferred. Both meal options looked tasty and colourful. We saw one person was offered a smaller size fork to help them eat independently, which they accepted. Staff assisted people to cut up their food and encouraged people to eat as much as they could. Staff spent time with people and we observed that no-one was rushed to eat their food and there was a relaxed atmosphere throughout. Specialist diets were catered for, for example, one person was a vegetarian. There was one option available, but staff said that if this was not to the person's liking, they could be offered an alternative such as omelette or jacket potato. Another person required a pureed diet which was nicely presented in sections with extra gravy. There did not appear to be a choice for the person on the pureed diet, but the registered manager said an alternative would always be offered if requested.

People were supported to maintain good health and had access to healthcare professionals and support. Relatives told us that healthcare professionals would always be consulted as needed. One relative said, "When there is a deterioration, the girls are brilliant; they get the doctor or the diabetic nurse out. They are very observant and they always phone if there is a problem". Care plans documented when various healthcare professionals had visited and any follow-up actions required. We observed one person was complaining of pain in their arms. A member of staff suggested that the GP be called to look at prescribing appropriate analgesia as paracetamol did not appear to be effective. Staff later told us that the GP had been contacted and was due to visit the next day.

People's individual needs were met by the adaptation, design and decoration of the home. In the Richmond suite, a 'tea room' area was used as a quiet or reminiscence room for people with their visitors. The room was furnished with a piano, a child's buggy, cuddly toys and furniture in keeping with an old fashioned lounge, a dresser with ornaments and a corner china cabinet. A relative told us, "The tea room is brilliant, but I am not sure if it is used. There might not be enough staff to take people there". They added, "The garden is neglected. In summertime it is nice, but now there is nothing to look at, no colours". Our observation was that the gardens were not unduly untidy, given the time of year. All bedroom doors had memory boxes which contained items that were relevant to the occupant of the room. The suite had an air of homeliness and was charmingly decorated for Christmas with trees and hand-knitted stockings hung over the mantelpiece. Mobiles above the door to the lounge provided a sensory interest, especially if doors to the garden were open.

Good

Is the service caring?

Our findings

At the inspection in September 2015, we found the provider was in breach of a Regulation associated with dignity and respect. Some people's expressed choices and preferences were not respected or considered by staff. We asked the provider to take action because people were not always treated with dignity or respect by staff. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

We observed that when people were being supported with their personal care by staff, signs were in use on bedroom doors which stated, 'Care in progress', thus ensuring people were given the privacy they needed. One member of staff said, "We knock on their doors, we don't just walk in. We shut the curtains and we cover them up". We observed a member of staff take one person to the toilet and they waited outside the door, checking with the person from time to time, that they were all right. Following our last inspection, 'Customer Care Service Workshops' had been organised by the provider. The registered manager explained, "Following the inspection we arranged for customer care training at Linfield. It was good for teambuilding and as a result the staff are much more caring. Staffing levels were increased too. It's made such a difference to staff morale and the residents have benefited considerably".

We observed one person, who had recently come to live at the home, was visibly distressed and anxious. The deputy manager spent a considerable amount of time with the person, checking whether it was okay to come into their room, then trying to stimulate their memory. The deputy manager said, "Do you remember you gave me a jigsaw puzzle?" and the person then recounted the story behind this. The deputy manager crouched down next to the person, explained to them where they were and why, about the staff and the polo shirts they wore. When the person stated, "I don't like the way that I'm treated here", the deputy manager responded sensitively saying, "How can we help, how can we change that?" They took a lot of time to listen to the person, holding their hand at appropriate times. When the person became anxious, the deputy manager engaged them in conversation about their past, and their wartime experiences in the RAF, which had a calming effect.

At the inspection in September 2015, we found the provider was in breach of a Regulation associated with person centred care. People or their representatives were not always involved in the assessment or review of their care. We asked the provider to take action because people or their relatives were not involved in reviewing their care. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

People were supported to express their views and to be actively involved in making decisions about their care, treatment and support. One person confirmed they were involved in reviewing their care plan, adding, "But not as much as I should", because they had recently been too unwell. Relatives told us they were involved in review meetings with staff. One relative said their family member was encouraged to make day-to-day choices and that they chose when to get up and when to go to bed. They added, "But her world has

contracted and she likes the experience of being led". The nursing staff contacted families on a monthly basis and a review form recording discussions was kept electronically within people's care plans. Another relative confirmed their involvement in reviewing their family member's care plan, either every month or at six weekly intervals. They told us, "It's important that staff know the residents and what works for different people. The staff are very proactive at diffusing a situation before it gets too difficult. They're worth their weight in gold". We looked at care records which confirmed that review meetings had taken place when care plans were updated. Review meetings were either face to face or by phone.

We asked a member of staff how they looked after people and knew about their care needs. They told us, "By asking people here and looking at the care plans in people's rooms. Most of it is through showing and learning from other staff". Another member of staff said, "We know the residents, we all know what they like and dislike". Care plans included personal histories about people and the management team had received advice from healthcare professionals on effective ways of collating personal histories for people. The registered manager told us that they had organised a game to test staff on their knowledge of people's personal histories. This had worked well. Staff were invited to match names of people with an interest or a memorable event associated with them. For example, who had been a librarian or who liked dancing. This was a fun way of encouraging staff to know about people through their personal histories. A healthcare professional stated, 'Staff are compassionate and have a fondness/attachment to each of their residents. The residents are very much treated as individuals with the staff genuinely interested in their life stories, etc. Staff gave us the impression that they enjoy spending time with their residents and that they understand and value the importance of psychosocial support for their residents. The staff also foster a supportive community atmosphere in the [Richmond] unit so that residents seem to experience a sense of inclusion and belonging'.

Positive, caring relationships had been developed between people and staff. We observed the registered manager offering a fresh cup of tea to one person as their drink had gone cold. One person referred to 'bickering' which sometimes occurred between people and that, "The manager gets involved and sorts it out. They do look after you. Staff are very nice and they joke with us. Some staff are chatty, some aren't. If you're nice to them, they're nice back!" Relatives spoke highly of staff. One relative explained that staff were very reassuring with people, saying, "The staff are very kind and very empathetic". They referred to their family member's memory loss and said, "Staff are very good at going with the flow in conversations". A staff member explained, "People lose their memories, not their feelings". We observed numerous occasions throughout our inspection when staff were attentive to people. For example, one staff member noticed a person was looking uncomfortable because they were sitting on a sling used for hoisting; this was removed. We also saw staff complimenting people on how nice they looked, their clothes and when they had their hair done by the visiting hairdresser. A healthcare professional stated, 'On one occasion, care staff spontaneously engaged with a resident by helping her to choose music to listen to and then to dance together'.

Good

Is the service responsive?

Our findings

At the inspection in September 2015, we made a recommendation that the provider review the programme of activities planned to ensure they were person-centred and met the needs of people, including those living with dementia. At this inspection, we found that the provider had taken action and that steps had been taken in line with our recommendation.

The home had been supported by the Care Home In Reach Team and advised on how to provide person-centred care that promoted people's wellbeing, especially people living with dementia. The provision of interesting and stimulating activities was key, at an individual level and with group activities. The management team had drawn up a development plan which suggested ideas for activities appropriate for people in small groups (six to eight people) or in larger groups. For example, smaller group sessions included Scrabble, quizzes, knitting and crosswords or puzzles. Larger group sessions included Bingo, a gardening club and music and movement. Activities were organised that were balanced to meet people's cognitive skills, spiritual needs and could be creative or relaxing. Work was in progress to create a 'My Activity Map' which recorded people's hobbies, special memories, pets, people important to them and what made them happy. Activities could then be arranged that were personalised to meet people's interests and social needs. During the week of our inspection, a programme of activities on offer included music and relaxation, music and singing from external entertainers, carpet bowls, gardening club and a church service. People could choose whether to attend activities or not. A relative told us, "They know what she likes in the way of activities. They try and persuade her to go into the lounge for company".

We observed people making Christingles, oranges studded with cloves and tied with ribbon, to hang on the Christmas tree. People were enjoying this activity and were supported by staff in the activity. We asked people whether they enjoyed the activities on offer. One person said, "I'm quite old, I can't do much" and we saw staff helping them to complete a crossword. A relative commented on activities in the Richmond suite and said, "They did try and do organised activities, but it didn't really work. They're doing more 1:1 things that are relevant to people now. I think the staff try and help people and provide mental stimulation to those who don't have anyone". People were encouraged to access the community through minibus outings or to go out with staff to a nearby park. An activities co-ordinator and activities assistant worked at the home and helped to provide a range of activities on a daily basis. On the first day of our inspection, carpet bowls had been planned, but people decided they did not want to participate in this activity. The staff member was flexible and immediately checked with people what they would like to do. The consensus was for a quiz to be held and people were observed to be engaged with this new activity.

Memory boxes encouraged people living with dementia to remember significant people or events of importance to them. One member of staff had, in their own time, made up a memory box for one person and had talked with the person and their son to help make the decision about what to include in the memory box. For example, the person had enjoyed decorating cakes in the past and so a few cake decorations had been included in the memory box. The member of staff told us that they planned to put together a memory box for each person in the Richmond suite as the first memory box had proved very successful. In addition to memory boxes, activities in the suite were 'short bursts' as many people found it

difficult to concentrate for long periods of time and might quickly become disengaged with a particular activity. The senior team leader explained, "I'm introducing short-burst activities like nail painting, decorating Christmas biscuits and foot spa. We do lots of little, different things and there is time for 1:1".

A healthcare professional stated, 'All the staff that we have supported on the [Richmond] unit have been very responsive to their residents and to our team input. They actively try to make their resident's lives as comfortable and enriched as possible by taking them to activities on other floors and when able, to support them on outings. The team are effective in responding to any distress in their residents and work as a team with outside agencies, families and the resident, to aim to problem-solve any difficulties. Recently we observed that they were effective in liaising with other teams to review a new resident's medication where they were able to lower (with a view to eventually stopping) a medication that was no longer required and could be affecting that resident's quality of life. They recognise that they are managing to do this by supporting the resident using psychosocial support rather than relying on medication'.

People's care plans were used to ensure they received care that was centred on them. Before people came to live at Linfield House, a pre-admission assessment was drawn up with the involvement of the person and others of importance to them, for example, relatives. We looked at one pre-admission assessment which covered personal care, nutrition, sight and hearing, communication, oral health, foot care, mobility, personal safety and risk, elimination and continence management, medication, pain, breathing and circulation, skin condition and pressure relief, mental and cognitive behaviour, overnight needs and sleep, social interests and hobbies, diversity and end of life. The pre-admission assessment recorded the person's interest and past work with the RAF, as well as information about their family, including grandchildren. It was noted that this person also enjoyed a glass of wine with meals and staff confirmed that wine was on offer, usually during the evening. The pre-assessment formed the basis for the care plan.

Care plans provided detailed information about people and included advice and guidance to staff on areas of support which built on the areas already identified in the pre-admission assessment. Care plans were based on observations of people, their goals and any interventions needed. For example, in one care plan we read for 'Sleep and resting', '[Named person] likes to watch television in the Frazer lounge after support. To be assisted to bed by the night staff'. Goals were identified as, '[Named person] would like to maintain the freedom and choice to decide her own sleep pattern with support'. Intervention was, '[Named person] will need staff to offer her a hot drink before settling. Three night staff to assist her to bed'.

Handover meetings held between shifts enabled staff to receive updates about people, their moods, visitors and on how to deliver their care. We observed a handover meeting in the Richmond suite and each resident was discussed. For example, "[Named person] has asked to go back for bedrest, so we've just done that". For another person, "Let him know what you are doing as he can be jumpy. He is absolutely lovely!" and "[Named person] is being nursed in bed today. We are doing a pain chart and she is still on a fluid chart. She is also on four hourly turns".

Complaints were managed in line with the provider's policy, acknowledged within three working days and responded to within 14 days. We looked at complaints received which clearly recorded the actions taken and outcomes, to the satisfaction of the complainant. One person told us that if they had any concerns they would talk to the registered manager or deputy. They said, "Everyone is very good".

Good

Is the service well-led?

Our findings

At the inspection in September 2015, we found the provider was in breach of a Regulation associated with good governance. We asked the provider to take action because personal information about people was not kept confidentially or securely. The provider did not have an effective system to assess, monitor and improve the quality and safety of the services provided. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

Records containing confidential information about people were kept securely in offices that were locked when left unattended. Access to these offices were via door keypads, the codes of which were only known to staff.

A range of systems had been put in place to measure and monitor the quality of care delivered and the service overall. Audits included assessments by the provider on how the service was run under the headings of 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well Led' and ratings had been allocated. For example, under 'Effective', areas monitored included staff training, supervisions and team meetings. Improvement actions included the need to implement a supervision structure and to ensure that team meetings were held monthly. In 'Caring', an improvement was identified as, 'Ensure residents/relatives involved in monthly review process' and we saw that action had been taken to address this. Accidents and incidents were analysed on a monthly basis and any emerging trends were dealt with. Medication audits were completed on a monthly basis, as were infection control and health and safety. In addition, observation audits were completed by the registered manager and deputy managers in various parts of the home. The management team spent time observing staff and whether social interactions with people were positive and that people received appropriate care. Feedback from these observation audits was shared with senior staff so that any areas for improvement could be acted upon. A development plan was in place operating from April 2016 until March 2017. This covered home management, environment, senior leadership, staffing (including staffing levels, deployment of staff and skills mix), residents, friends and family, volunteers and improvement monitoring.

High quality care was delivered and people and their relatives spoke highly of the staff and of Linfield House. A relative said, "Whenever I go home, I think I couldn't have found a better place for my mum". Another relative talked about their mother and said, "She was in another home for a couple of years, but then needed more nursing care. She's settled very well". They added, "This is the right place for my mum at this time of her life". Staff also spoke positively about working at the home. One staff member said, "I really like the staff and everyone knows what they're doing. I like the cleanliness of this home and it always smells fresh. I like the space. In the summer people go out in the garden or on the balconies. I would put my relative here, it's quite relaxed". Another staff member commented, "I think we do everything we can. We always strive to make things better".

People were actively involved in developing the service. People confirmed that residents and relatives' meetings took place and records confirmed this. We looked at minutes of a meeting held in November 2016

and these included information about people who had come into the home or who had passed away, two occupational therapy students who were on work experience, staff awards and staffing and plans for Christmas. Meetings were held monthly and minutes were in an accessible format, with the effective use of pictures and symbols to aid understanding. We asked relatives for their views about the home and one relative explained that the senior management team (based in the provider's head office) had been open and transparent in their communication, especially following the last inspection. Relatives told us that the senior management team had organised several meetings to obtain everyone's feedback and ideas on how the service could be improved. A newsletter, 'Linfield Times', also kept people and their relatives in touch with what was happening at the home. We looked at comments written by relatives. One relative wrote, 'I would like to commend the staff here at Linfield House, not just for their kind and compassionate nature, but also their dedication to providing a high standard of healthcare'. Another relative stated, 'I am full of gratitude for the work Linfield does. It's truly been my mother's home for the past eight years. The warmth and care and love that the staff demonstrate on a daily basis is amazing. Thank you for looking after Mum so well'. A survey was sent to residents and relatives in June 2016 with responses from three residents and 17 relatives. Overall results were positive.

Good management and leadership were evident. One relative said the registered manager and deputy managers were always visible and available. They explained, "I'm aware of [named registered manager and a deputy manager] in the office and having meetings with relatives. I'm not particularly aware of managers on the floor. They all work very well as a team and are very welcoming to me and visitors". Another relative talked about the managers and referred to their understanding and patience when their family member had recently moved into Linfield House. They said, "They've been so accommodating. [Named registered manager] has gone out of her way. They've moved heaven and earth". Staff were generally positive about the managers and felt supported. One staff member said they had no problems with the management and that they were, "Supportive and approachable". We asked the registered manager for their comments and discussed the improvements made since our last inspection. They said, "I'm so proud of it now and I can see the differences; it's about teamwork too. It hasn't been an easy year, but it's nice to see improvements. And I like to think I support my staff".