Sussex Partnership NHS Foundation Trust

Lindridge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Lindridge is a residential nursing home providing personal and nursing care to 29 people aged 65 and over at the time of the inspection. The service can support up to 75 people. The home is comprised of five wings, each of which has separate adapted facilities, one of which was vacant on the day of inspection. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were not always supported by a consistent, clearly visible management team. People and relatives did not know who to go to, to raise a concern or an issue. Some relatives were frustrated with the lack of communication when a person's care needs changed.

Accidents and incidents were recorded in separate ways. There were clear systems to identify which incidents needed to be reported to CQC or the local authority. The incident details were also transferred to a dashboard to identify trends and patterns. With the absence of a manager to have oversight of analysing trends or implementing an action plan was not always completed in a timely way.

The home used agency staff frequently and they did not always know about people's needs and risks. Relatives voiced concerns about lack of knowledge of agency staff. In addition, care plans lacked person-centred detail or guidance for agency staff to follow. Attempts had been made to have regular agency staff to prevent further risks of the spread of Covid-19.

Risk assessments in people's care plans lacked detail. People were confident that permanent staff members knew them well. However, the lack of detail in care plans could lead to agency staff struggling to understand people's individual risks and keeping people safe.

People told us that staff supported them with their medicines. However, medicines management systems did not always identify medicines errors.

People told us they felt safe at Lindridge and relatives told us that they felt that the home was overall safe. The pandemic had resulted in unprecedented challenges across the adult social care sector. We saw evidence of the service working to keep people safe and effectively manage the outbreak of Covid 19. Safe infection control policies and procedures were being followed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection

The last rating for this service was Good (published 22 August 2019).

Why we inspected
The inspection was prompted in part due to concerns received around safeguarding incidents, the management of the service and an outbreak of COVID-19. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurances that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this focused report. You can see what action we have asked the provider to take at the end of this full report.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lindridge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Lindridge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors who attended the location and a third inspector who completed calls to relatives of people using the service.

Service and service type
Lindridge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager of the service had resigned following a brief period of leave and sickness, recruitment had begun for a new manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with eight members of staff including the deputy chief nurse, the newly positioned clinical lead, the business manager, nursing staff, care staff and a maintenance staff member.

We reviewed a range of records. This included three people's care records and ten medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at rotas, staffing levels, infection control and medicine audits. As well as accident and incident analysis and action plans. We also looked at training data and quality assurance records. We spoke with a further maintenance director and two professionals who regularly visit the service. We also spoke with six relatives of people who used the service about their experience of the care provided.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risk assessments were not always detailed with advice for staff on how to manage risks. There were areas of care plans and risk assessments that had not been completed. One person's care plan had an area for mental wellbeing to be considered, however, it stated that it was not needed due to the person having capacity. Further correspondence from a health professional showed that this person had suffered anxiety around certain aspects of living in the home, however, a risk assessment around this had not been completed. Staff were not aware of this potential anxiety risk either, this left a risk unidentified, and staff unaware of how to manage the risk of anxiety if it occurred.

● Reviews of risks were not always completed in a timely way. One person's health had deteriorated quickly over the last few months. These changing needs and risks had not been documented in the care plan, and these were only established from speaking to a member of permanent staff. The lack of up to date information meant that it was difficult for agency staff and new members of staff to know the person's current risks and monitor them correctly.

● Care plans and risk assessments were not always reviewed in a timely way and some lacked up to date detail. One person's care plan had advice for staff from the Speech and Language Therapist (SALT) team. This detailed what thickener level to use to avoid choking, however, a different point in the plan, there was differing advice for staff with regards to what thickener level to use. It was established that new advice had been received from the SALT team and permanent staff were aware of the new guidance. Concerns were raised as to how new members of staff or agency staff would be aware if they were using the care plan to guide them through people's needs. Although the person had not experienced a choking incident, the risk of the incorrect consistency being provided was present, therefore, a choking incident was possible.

● People's care plans lacked detail of their past history which meant some risks could remain unidentified by staff. For example, due to no detail about histories, there were no details about significant events in people's lives or people that were important to them. In addition, there was a chance that vital risks such as behaviours would have been missed with the absence of this thorough assessment process.

Using medicines safely

● People told us staff supported them with their medicines, however, the management of medicines were not always clear and safe practises were not always followed. For example, running totals were not always recorded, which made it difficult to identify a medicines error which could be avoided or acted upon quickly. A clinical lead had started work two days before the inspection. At the time of the inspection audits were being completed monthly by a pharmacist.

● The registered manager had not ensured people had the medicines they needed. There had been errors in ordering where people had been unable to take essential 'as and when' medicines. One example was

where a person had been unable to take medicines for a breathing condition due to their nebuliser not being ordered in a timely way. This resulted in the person being supported by a paramedic to relieve them.

The lack of medicine management oversight and adequate risk assessments is a breach of regulation 12 : Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider responded immediately during and after the inspection. Following the inspection, the provider informed us of a part time pharmacist that was based in the home that had not been present at the inspection. They also confirmed a new role of pharmacist technician had been recruited to be based at the home, who would complete regular medicines audits. The provider also confirmed that they were in the process of reviewing and improving all care plans and risk assessments to add to a new online care plan system. As a matter of priority, they addressed the out of date guidance in relation to the SALT advice for staff.

● Permanent members of staff showed good knowledge of people's current independent risks. Relatives told us that they were confident the permanent staff could keep their relatives safe. One relative said, "I think that some of the staff are very good, but they have a high turnaround in staff. Because of (my relatives) cognitive impairment they don't always recognise staff because the faces change."
● There were some examples of thorough risk assessments seen in other care plans. These included detailed falls risk assessments and malnutrition risk assessments being reviewed regularly. However, these were not present in all care plans.
● Covid-19 measures had been implemented and risk assessments completed to ensure the risk of spread of infection was minimised.

Staffing and recruitment
● Some staff and relatives told us there was not enough staff to support people at the home. The home worked in line with a dependency tool, which assessed people's needs and calculated the minimum number of staff required to support people safely, this was followed and rotas showed that the dependency tool was complied with. However, this did not always identify a mix of experienced nursing staff required to ensure people's needs were safely met.
● There were mixed reviews about staffing levels and competency. One person said, "They have seemed a bit busier and have less time, but I guess that is having to account for the pandemic and all the extra precautions.". One relative said, "I don't have any concerns with moving and handling, but I would say the call bells are not answered quite quickly. I've not been in the room since February though. I think staff know (my relative) pretty well although they do seem to have quite a lot of agency staff, including the nursing staff, especially at the weekend." Another relative said, "What I would like to see at Lindridge is adequate staff numbers and well-trained management. We need a reliable point of contact."
● Staff also told us that there were some gaps in knowledge due to agency staff being used. One staff member said, 'Staff numbers have increased due to COVID. We use a regular agency but we have enough staff. There is a slight issue with the lack of regular RGNs (registered general nurses) rather agency nurses. Current management are aware of this but it's still a bit of a problem. Agency RGNs wont know people the way permanent nurses will.'
● During observations of care support staff, staffing levels appeared to be correct, safe levels. Care staff did not appear rushed and appeared to know people by name and were seen to know people's preferences.

We recommend that Lindridge re-visit the effectiveness of their dependency tool ensuring a range of experience throughout the allocations.

● Lindridge followed safe recruitment processes. This included full reference checks, interviews and checks completed with the Disclosure and Barring Serving (DBS). This confirmed if potential new staff members were known to the police and suitable to support the people living in the home.

Learning lessons when things go wrong

● Staff recorded accidents and incidents and this was then transferred to a dashboard on a digital system. This dashboard was accessed by all leads of departments, for example the deputy chief nurse and the lead nurse for quality assurance had access to the dashboard. This then set actions to take to avoid future re-occurrence. Staff were unaware who would be responsible for oversight of this and to identify trends and patterns whilst the management was absent from the home. It was established on the day of the inspection these action reports were still being sent to the management team, both of whom were off work with sickness. Immediately after the inspection we were assured that a new member of the management team would have oversight of this.

● The provider and other leads of departments within the organisation stated they were keen to learn as a result of accidents and incidents.. There was an improvement plan in place to try to make efforts to make positive changes to the home.

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us they felt safe living at Lindridge. One person said, "Oh yes, I feel very safe, it's such a secure home and the staff always make me feel very safe." One relative said, "My (relative) is safe, and the security is safe. They (staff) are very good I haven't had any concerns."

● Staff could identify different types of abuse and were confident of the procedure to follow to report a safeguarding concern. One staff member said, "It is my priority to keep people safe, If I saw anything that sparked concern, I would act immediately."

● The provider had in place a safeguarding policy for staff to follow. Staff also received regular training in safeguarding.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- On the day of inspection, inspectors found there was a lack of clarity by staff about the management structure and who was in charge on the day. The registered manager of the service had resigned following a brief period of leave and sickness, and recruitment for a new manager had started. The deputy manager was also away on leave, this made it difficult to understand the different department roles. It was not always easy to establish who was responsible for the oversight of the home and various integral departments within the home.
- Some staff told us that they had not always felt comfortable voicing concerns to the previous registered manager and had not always felt supported. One staff member said, "It definitely was not an open door policy. We felt like we were bothering her. The deputy is a lot more approachable, but unfortunately she is off now as well."
- All people and relatives we spoke with could not tell us the name of the manager and relatives told us that the lack of presence of a manager that has overarching management oversight was frustrating. One relative said, "The manager used to be [deputy manager] but I haven't seen her for a long time. They don't notify us, I have to ask where the staff are." Another relative said, "There's no real point of first contact, I don't know who to get in touch with and it keeps changing. Emails have been ignored – we [family] have a generic email address that we used. We have also emailed [deputy manager] and [registered manager] – huge lack of responses. We met with [registered manager] for a consultation in September and we thought we were going to get somewhere but we didn't ."
- Some care plans did not contain person-centred details to enable staff to understand people's care needs. The lack of detail in people's histories meant permanent and non-permanent staff could be unaware of a person's specific needs and how best to support them. For example, if someone had previously suffered with anxiety or behaviour that challenges this could identify triggers and ways best to support people if these behaviours arose.
- Quality assurance audits had been completed for the home. However, these had not identified the issues found at the inspection. For example, the lack of person-centred detail in care plans and continued lack of management oversight of medicines.
- A medicines audit completed in September 2020 highlighted concerns around staff not recording running totals of medicines on medicine administration record (MAR) charts. This had been added to the improvement plan for the home. However, during the inspection examples were seen where running totals

were still not being recorded. This was of concern as to how a medicines error would be identified in a timely way.
● Actions and decisions of the management team were not always recorded correctly. We found a concern in relation to deprivation of liberty safeguarding records. A person had been restricted and a risk assessment completed. However, this had not been included in the mental capacity assessment, Best Interests decision or Deprivation of Liberty Safeguards paperwork. The provider ensured this was corrected after this was highlighted to them.

The lack of management oversight and correct record keeping was a breach of regulation 17: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager and the provider have a responsibility to notify CQC and the relevant authorities of significant incidents. We found that these were not always made without delay. There were a number of notifications that were made retrospectively only after CQC had made contact with the home. For example, there were a number of safeguardings that were only discovered by CQC due to the local authority sharing information. When this was raised with the home they retrospectively notified us of these events.
● The provider wanted to work with the local authority and CQC and make the required improvements.
● People felt listened to by the staff at the home. One person said, "I know staff will always help me and really listen to me. If I tell them to do something a certain way, they take it on board. They're lovely."
● Staff told us that they felt they benefitted from staff meetings. One staff member said, "Yes, we have regular staff meetings where we can put ideas across and voice concerns if we need to."

Continuous learning and improving care; Working in partnership with others
● There was an improvement plan in place that was addressing various areas that required improvement. These changes were progressing slowly as the provider was currently recruiting a new registered manager.
● Action plans had been set to improve the care home. However, these were delayed due to a lack of permanent management.
● There was evidence in care plans that regular advice was sought from health professionals. One care plan detailed advice from a dietician for staff to support people with nutrition and hydration.
● Staff were working closely with the local authority to drive improvement. This included an action plan and updates to the local authority about how positive change was happening.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The lack of medicine management oversight and adequate risk assessments is a breach of regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The lack of management oversight and correct record keeping was a breach of regulation 17: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance