Lincoln House Care Home Ltd

Lincoln House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on 11 and 12 November 2015.

Lincoln House Care Home is a service that provides accommodation and care for up to 60 older people, some of whom may be living with dementia. The service is split into three areas, a nursing wing, a residential wing and it also has three intermediate NHS beds. On the day of the inspection there were a total of 51 people living at the home.

There was a registered manager employed at the home. 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 and associated Regulations about how the service is run.

People who lived at Lincoln House Care Home felt safe and were happy living there. Relatives were also happy with the standard of care that was being provided and most people we spoke with recommended it as a place to live.

People were cared for by kind, caring and compassionate staff who listened to people and made them feel valued. However, there were not always enough staff to support people which resulted in some having to wait for long periods for assistance. This on occasion, compromised their dignity. Not all people's medicines were being managed safely.

Most people's preferences on how they wanted to be cared for were being met and people had a choice about the care they received and how it was delivered. People were asked for their consent by the staff before they started a task. However, the staff had a limited knowledge about how to provide care to people who lacked capacity to make their own decisions in line with the principles of the Mental Capacity Act.

The equipment that people used had been well maintained and risks to the safety of the premises were managed well. People had access to a choice of food and drink however, some people's risk of not eating or drinking were not being managed effectively to make sure that they received sufficient food and drink to meet their needs.

People were provided with a number of different activities to complement their hobbies and interests and any complaints made were investigated. The staff felt supported in their roles and were able to raise any concerns to the management team without fear of recriminations.

A number of improvements had been made recently to the home. The registered manager had plans in place to continue to make improvements to the quality of care that people received. However, some systems that were currently in place to monitor the quality of service given were ineffective which meant that people had or were at risk of experiencing poor care.

There are some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we have told the provider to take at the back of our report.

We have made recommendations regarding following the principles of the Mental Capacity Act 2005 when making 'best interest' decisions on behalf of people.

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 consistently safe.

There were not always enough staff to meet people's needs in a timely manner.

The risks in relation to people receiving their medicines correctly were not being managed effectively.

The provider had systems in place to reduce the risk of people experiencing abuse.

Risks to people's safety had been assessed and management plans to reduce any risks were in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Appropriate action had not always been taken to ensure that people received enough support to eat and drink sufficient amounts.

Staff did not fully understand their legal obligations when providing care to people who were unable to consent to it.

People had access to a choice of food and drink and specialist diets were catered for.

People were supported by the staff to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was compromised on occasions.

The staff were kind, compassionate and caring.

People were involved in making decisions about their care and were encouraged to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual needs and preferences had not been fully assessed and were not always being met.

Plans of care were not always in place to provide staff with guidance on what care people needed.

Staff supported people to access activities to complement their hobbies and interests and to enhance their wellbeing.

The provider had a system in place to investigate and deal with complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some of the systems in place to assess the quality of the service being provided were not always effective at identifying issues of concern.

Staff felt supported in their role and were able to raise concerns which were listened to and dealt with.

People were happy living at the home and felt listened to and valued.

Lincoln House Care Home

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.

This inspection took place on 11 and 12 November 2015 and was unannounced. The inspection team consisted of two inspectors, an inspector who specialised in medicine management and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

During the inspection, we spoke with 14 people living at Lincoln House Care Home, three visiting relatives, 11 care staff, one nurse, the activities co-ordinator, the cook, the deputy manager and the registered manager. Some people were not able to communicate their views to us and therefore, we observed how care and support was provided to some of these people. To do this, 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.

The records we looked at included ten people's care records, 16 people's medicine records and other records relating to people's care, four staff recruitment files and staff training records. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Nine of the 14 people we spoke with and two of the three visiting relatives told us that they did not feel that there were always enough staff to provide them or their family member with care when they needed it. People told us that they often had to wait for assistance with personal care which made them feel uncomfortable and frustrated. They added that sometimes the staff would turn off their bell and then not return to them for some time. One person said, "I will tell you honestly that I did wait 50 minutes for my buzzer to be answered." Another person said, "The buzzer is not always answered as quickly as I would like or expect. Fifteen minutes is the longest I have waited." A further person told us, "I suppose the one thing that probably needs addressing is the number of staff. It's a good home, but you do have to wait for things. Staff can take time to get to you. To me that says more carers are needed." Another person said, "Sometimes there is not enough staff here and when I ring the call-bell the staff take a long time to come to me. When they do arrive they often turn the bell off and say they will be back soon, but then they do not return until at least 15 minutes later. Sometimes more." A relative said, "My wife has dementia and needs lots of care. I have timed the bell response as 45 minutes on two occasions." Another relative told us, "The buzzers are not answered promptly. It could be a 30 minute wait. There are less carers in the afternoon. There's a definite shortage, especially at weekends." We also saw that another relative had recently made a complaint where they had stated that their family member had had to wait for 30 minutes for staff to attend a call. This complaint was currently being investigated by the registered manager.

On the day of the inspection, we saw that most people's requests for assistance were answered in a timely manner and that there were enough staff to provide people with assistance with their lunch if they needed this. However, we did see that one person had to wait for assistance with personal care which caused them some distress. A staff member acknowledged the call bell, turned it off and told the person that they would be with them shortly as they were helping another person. However, the staff member did not return promptly and the person told us that they were desperate for the toilet and that they were uncomfortable. We therefore alerted staff to this and we saw that the staff eventually went to help the person 15 minutes after they had initially rang their bell. Some other call bells did take up to seven minutes to be answered.

Some people told us that they were able to have a bath or shower once a week but that they wanted to receive these more frequently. One person said, "I have a bath once a week but would like more but they haven't the time or the staff to do that more often. They just tell me it isn't possible." Another person told us, "It would be nice to have the choice of more baths or showers in the week." A relative told us, "[Family member] gets just one bath a week but would like more. They must be short staffed." The staff on the nursing unit told us that they were able to offer people as many bath and showers as they wanted. However, the staff on the residential unit said that they only had time to provide one bath per week to people and that there were not enough staff to provide baths more frequently than this.

The staff told us that a total of 20 of the 51 people living at the service required two staff members to assist them with personal care and to support them moving. The registered manager told us that the number of staff available to assist people during the morning were one to two nurses, two senior carers and ten care staff and in the afternoon, one to two nurses, two senior carers and six carers. One nurse worked with five

care staff during the night. Some staff told us that due to the number of people requiring two staff to assist them with their care, this sometimes impacted on their ability to help people in a timely manner. They also advised that staff shortages were particularly noticeable at the weekends when sometimes absences were not always covered. Staff did add however, that more staff had recently been recruited to work in the home and that therefore, things were improving and they were confident that this improvement would continue.

We checked 28 days of staff rotas and found that on four of these days the home had functioned below the number of staff that had been assessed as being required to meet people's needs. Three of these occasions had been on a weekend. However, there were always nursing staff available if people required assistance with their nursing needs.

We asked the registered manager how she decided the number of staff that were required to work on each shift. She advised us that she and her deputy manager discussed people's individual needs and then worked out how many staff were needed. However, an explanation of how the calculation was made to decide the number of staff required was not given. No documentary evidence was available to demonstrate this. We have therefore concluded that there are currently not enough staff to meet people's needs in a timely manner or all of their preferences.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager advised that there were currently no vacancies for care staff but two vacancies for nursing staff which they were confident would be filled shortly. They acknowledged that there had been issues with staffing levels and told us they and the provider had worked hard to recruit a full complement of staff, a number of whom were currently going through their induction period. She explained that with the home being in a rural area, that transport was an issue which made it difficult for them to recruit. To help with this, some of the staff lived on site. The registered manager told us that existing staff covered any unforeseen absences and that she was building up a bank of staff to also make sure that there were staff available if needed at short notice. Agency staff were also used when other avenues to cover absences had been exhausted.

All of the people we spoke with told us they received their medicines when they needed them. However, people's medicine records did not confirm that they had received their medicines as intended by the person who had prescribed them. When we compared medicine records against quantities of medicines available for administration, we found numerical discrepancies and gaps. This included the records in relation to medicines prescribed for external application such as creams. We found there was a discrepancy for a person's anti-inflammatory medicine. This medicine had been the subject to a previous investigation by the registered manager as an incorrect amount of it had been given to the person. There were also discrepancies for the anticoagulant medicine warfarin.

Supporting information was available alongside medicine records to assist staff when administering medicines to individual people. These included a photograph of the person who help staff identify they were giving the medicine to the correct person and information about known allergies and medicine sensitivities. Additional charts were in place to record the application and removal of skin patches.

When people were prescribed medicines for occasional use such as pain killers, there was no written information available to show staff how and when to administer these medicines. In addition, records showed that where these medicines had been administered, there was no information recorded to explain why they had been needed. Therefore people may not have had these medicines administered consistently and appropriately. For people who managed some or all of their own medicines, records did not show the

risks in relation to this or the support that staff needed to provide to ensure people received their medicines safely.

Medicines were stored in dedicated clinic rooms at the home. However, improvements to security were needed to ensure medicines were stored safely. This was because there was a key code on the door but most of the staff were aware of this and not just those who gave people their medicines. The code had also not been changed when staff were no longer working for the home increasing the risk that they could be accessed by unauthorised people. We also saw that medicines requiring refrigeration were stored at temperatures above the accepted temperature range and therefore may have been no longer safe and appropriate to use.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

All of the people we spoke with who lived at Lincoln House Care Home told us they felt safe living there. One person told us, "I'm happy and secure here." Another person said, "Yes I'm safe here. I trust the people who care for me." This was echoed by people's visiting relatives. One relative told us, "[Family member] is safe here." People and the visiting relatives we spoke with told us that they would have no hesitation in speaking to the staff if they were concerned about safety.

Staff had received training in safeguarding adults and were able to demonstrate to us that they understood what constituted abuse and that they were clear on the correct reporting procedures if they suspected that any form of abuse had taken place. We saw that any safeguarding concerns had been reported to the relevant authorities by the provider and fully investigated by them, with action taken as appropriate. We were therefore satisfied that the provider had systems in place to reduce the risk of people experiencing abuse.

The majority of risks relating to people's safety had been assessed and regularly reviewed. These risks had been assessed depending on the individual's lifestyle and we saw that actions had been taken to reduce these risks. For example, people who had been assessed as being at high risk of developing a pressure ulcer had pressure relieving equipment in place. However, we did see that one person who had experienced a recent fall had not had their risk of this assessed. This was despite their initial assessment when they had been admitted to the home, showing that they had a history of falls. We spoke to the registered manager about this who immediately put a risk assessment in place to help promote the person's safety.

We saw that people were able to take informed risks if they wished to do so. Examples were seen where people were advised of the danger of using certain equipment to assist them to move, or when eating certain foods when they were diabetic or when they were at risk of choking. The registered manager confirmed that these people had capacity to makes these decisions. We saw that the staff had clearly informed them of the risks to their safety but that their decision to take an informed risk had been respected.

Risks in relation to the premises had been assessed and regularly reviewed. We saw that fire doors were kept closed and that the emergency exits were well sign posted and kept clear. Testing of fire equipment and the fire alarm had taken place. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire or finding someone unresponsive within their room. The equipment that people used such as hoists had been regularly serviced to make sure they were safe to use.

Any accidents or incidents that occurred had been recorded and fully investigated. Actions had been taken in an attempt to reduce the risk of the same event happening again in the future. The staff we spoke with

had a good knowledge about risks to people's safety and told us they reported any accidents or incidents to the senior staff.

The required checks had been completed when recruiting new staff to the service such as obtaining character references and checking with the Disclosure and Barring Service that the staff member was safe to work with people. This reduced the risk of employing staff who were unsuitable to work in care.

Requires Improvement

Is the service effective?

Our findings

We looked at some people's care records in depth in relation to their risk of not eating and drinking. Although we found that some people's risk had been regularly assessed and appropriate action taken in relation to people not eating and/or drinking, we saw that this was not the case for everyone.

For example, it had been recorded in August 2015 that two people should be weighed weekly due to their high risk of not eating enough. However, this had not been done. We saw that these people had been weighed monthly since August 2015 and that they had lost some weight. The risk in relation to them not eating had not been reassessed since this time. Neither of these people had been referred to their GP or a dietician for specialist advice about weight loss. It had been identified in one of these people's care record that they should receive milky drinks to provide them with extra calories. However, the staff we spoke with told us that these were not being provided. Neither of these people were receiving any supplements to assist them with their weight and were not having their foods fortified with extra calories.

For four people at risk of poor nutrition, their food intake was not being monitored to make sure that it was sufficient for their needs. It was recorded within the daily notes of one person who had been assessed as being at risk of not eating, that they had not eaten very well in recent days. It had been recorded that they had lost nearly 4kg in weight in the last six months. However, no action had been taken to monitor that what this person was eating was sufficient for their needs.

We saw that people had access to drink within their rooms or communal areas of the service and that staff prompted people regularly to drink fluids. However, staff told us that some people were at risk of dehydration but an assessment of this risk had not taken place. One person who staff told us was at risk of dehydration was having their fluid intake recorded but only when they were in bed. When they were in the communal areas of the home this was not recorded. Therefore, this made it difficult for the provider to make sure that the person was receiving sufficient drinks for their needs. We spoke to the registered manager about these issues. She agreed to investigate these immediately and take any action that was required.

We have concluded that not everyone's risk of not eating and drinking was being effectively managed. This has resulted in a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The registered manager advised us on the day of our inspection that the staff were to receive refresher training in this area the week following our inspection.

People told us that they liked the food. One person said, "I like the food. It is tasty and there is plenty of it." Another person said, "The food is very tasty. I can have more if I want." A relative told us, "The food has definitely improved since they moved from frozen to fresh food."

People told us they had a choice of food and drink and that if they didn't like what was on the menu, they would be made an alternative. One person said, "They [the staff] ask me what I want but if I don't like it, I can request something else." Another person told us, "I can have an alternative. I like the tea when we get soup, sandwiches on white or brown bread and then say gateau or fruit."

The food was freshly prepared by the cook who had a good understanding of people's individual likes and dislikes and was aware of those people who required a specialised diet. Where people required a specific diet to reduce the risk of them choking, we saw that they received this and that each component of the meal was prepared separately to make the meal look appetising.

We observed that people had access to plenty of fluid during the inspection. People told us that they always had access to a drink when they needed it. One person said, "I always have enough water to drink." Another person said, "There is always a drink by my side if I want it." We saw that people were able to enjoy an alcoholic beverage with their main meal if they wished to.

The staff told us that there were some people who lived at the service who lacked capacity to consent to their care and treatment. This means that the provider has to comply with the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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. 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 are called the Deprivation of Liberty Safeguards (DoLS).

The staff we spoke with were able to demonstrate how they supported people who lacked capacity to make day to day decisions. For example, one staff member told us how they showed people their clothes so they could make a decision about what they wanted to wear or by showing people different meals they could choose. However, they did not have a good understanding of the MCA and DoLS and how this important legislation impacted on their daily care practice.

We saw that some people's capacity to make decisions had been assessed and related to specific decisions but not in all cases. For example, two people had sensors in their mattresses on their beds. The staff told us that these were in place so that the people could be monitored when they got out of bed to help the staff protect them from the risk of falls. The staff told us that these people lacked capacity to consent to these sensors. No assessment of their capacity had been completed in relation to these sensors. These people had also not been assessed to see if they were being deprived of their liberty in anyway. We fed this back to the registered manager who advised that she would look into the matter as she felt that these people had capacity to consent to these sensors. Therefore, improvements are required in this area to make sure that the provider and the staff are complying with the principles of the MCA and DoLS when providing care to people who are unable to make decisions for themselves.

The people we spoke with told us that they felt the staff were well trained. One person said, "Yes, they [the staff] seem to know what they are doing." Another person told us, "All of the staff are brilliant." A relative told us, "I certainly am confident that the carers know what they are doing in general." Another relative said, "The staff are good at what they do."

All of the staff we spoke with told us they had received enough training to provide people with the care they needed. This included in areas such as assisting people to move, dementia, infection control, medicines, fire safety and safeguarding adults. However, some of them stated that they were aware that certain areas of their training required renewing and the records we reviewed of staff training confirmed this. We spoke to the registered manager about this. She told us that she was aware that some staff refresher training was overdue and that this was being managed by the provider's training manager. We spoke to the training

manager who confirmed that this was the case, with a number of staff booked on future training courses.

The staff told us they regularly had their competency assessed to make sure they had understood the training they had received. This included observation of areas such as helping people to move, reducing the risk of infection and treating people with dignity and respect.

We spoke to some staff who were new to working at the home. They told us they had spent time shadowing more experienced staff and had been observed regularly during this period and given feedback on their performance. The registered manager made sure that new staff were competent to work with people on their own before they were allowed to do this. She confirmed to us that any new staff employed by the home would be completing the Care Certificate. This is a recognised training certificate that has been designed to provide staff working within health and social care with the skills and knowledge they need to provide a good standard of care.

We received mixed views from the staff regarding the standard of supervision they received. Formal supervision is important as it gives staff an opportunity to discuss their performance and development needs. Some were happy with this. However, others told us they could not recall when they had last received formal supervision with their manager. They said that they would like more supervision than they were currently receiving. We therefore checked some staff supervision records and found that a number of staff had not received an annual appraisal or recent formal supervision. The registered manager advised that she was aware of this and that the current staff structure was being changed. She confirmed that once set up, staff would receive supervision every six to eight weeks and appraisals each year. Therefore, improvements are being made to ensure that staff receive regular supervision and appraisals.

All the people who lived at the service and visiting relatives agreed that the staff always gained their consent before providing them with support. One person told us, "The staff never tell me what to do, they always ask me and I choose." Our observations during the inspection confirmed this. For example, people were asked if they wanted a meal or drink or whether they wanted to be assisted with washing and dressing.

People told us that they were supported by the staff with their specific healthcare needs. One person said, "If I want to see the doctor, this will be arranged for me." A relative told us, "I know the home would respond if [family member] needed medical attention outside of here."

The GP surgery was located opposite the home and GP's visited regularly to check on people's health and to see people if they were unwell. People also had access to other healthcare professionals such as occupational therapists, physiotherapists, chiropodists, dentists and district nurses. We saw that these healthcare professionals were called in a timely manner when people became unwell or required support with their health. We were therefore satisfied that the staff supported people with their healthcare needs.

We recommend that the service considers current guidance in relation to assessing people's consent in line with the principles of the MCA 2005 so make sure that people's rights are respected.

Requires Improvement

Is the service caring?

Our findings

Some people's dignity was compromised on occasions when they had to wait for staff to support them with personal care. People were not always able to have a bath as often as they wanted which also impacted on their dignity. This showed that the service was not always caring and therefore, improvements are required within this area.

People told us that the staff were very kind and caring. One person told us, "The staff here are a bit special as far as I'm concerned. They are so kind and will have a chat with me. We have a laugh and we tease each other. I am a person to them, not just a job to be done. I can't ask for more." Another person said, "I love them all, every one of them. I am so well looked after. We talk to each other like old friends. It means I have a good life here." A further person told us, "The relationship with the carers is a good one. They are certainly very busy, but they realise it is important to snatch conversations with you because that's how they get to know our moods as well as our needs. Anyway we ask them things about what they get up to. I feel I matter to them which makes me feel good as a person." A relative told us, "The carers are very sweet and lovely all round."

When staff interacted with people, this was done in a kind and compassionate manner. For example, we saw one person become distressed. The staff member spoke to them quietly and in a calm, dignified manner and asked if they were alright. The person said no and that they needed help. The staff member offered to make them a cup of tea and spent time talking to them until they were calmer. During the lunchtime meal, staff assisted some people with their meals. This was done in an unrushed and caring way. People ate and drank at their own pace whilst the staff sat next to them, telling them about their meal and engaging with the person. Gentle and friendly encouragement was given to people whilst they were eating their meals.

People told us they felt the staff knew them well. One person said "The staff all know me well and deal with my needs." Another person told us, "Yes the staff are interested in me and know what I need." A further person said, "The staff are first class, they know how to look after me and understand my stroke problems." The staff demonstrated to us that were knowledgeable about the people they cared for. This included people's likes and dislikes and preferences such as what time they liked to get out of bed in the morning, their interests and their life history. Staff told us that this helped them develop a good rapport with people and that knowing their history enabled them to have conversations with people that were meaningful to them. One staff member showed us some plants they had arranged to have placed outside a person's room as they knew that they liked plants and flowers. The person regularly tended these plants.

People and their relatives if appropriate, were involved in the planning of their care or that of their family member. The initial assessment of the person's care needs and preferences had been conducted with them and they were regularly asked for their opinion about their care by the staff at various times throughout the year. We saw that people were able to make choices and decisions about their care. Some people liked to have the doors to their rooms closed whilst others wanted them open. Some people did not want to be looked in on during the night where as others did and some people liked to stay in their rooms whilst others liked to be within the communal areas of the home. People liked to eat their meals in various places

including the dining room, the lounge or their own room. We observed people independently accessing the outside area for some fresh air or to smoke if they wanted to. All of these choices were respected by the staff and were catered for.

The home had set up a 'wish tree'. This was where people could express something that they would like to do that was important to them and placed the information on the tree. People were then supported by the staff with these 'wishes'. We saw that one person wanted to make a cake and that staff had supported them to do this. Another person had wanted a crab for their lunch and received this. The staff also told us they had made sure this person received crab regularly when it was in season. Another person had wanted to visit a place within the community that had special meaning to them and this had been taken place with assistance from the staff.

People told us that they were encouraged to remain as independent as possible. Some people were involved in running a small shop that had been set up in the home and other people could buy items from this shop to give them a feeling of independence with shopping.

People's spiritual, cultural and diverse needs were respected. Representatives from various faiths attended Lincoln House regularly to support people with their beliefs.

Requires Improvement

Is the service responsive?

Our findings

Most of the people we spoke with were happy that most of their individual preferences about how they wanted to be cared for were met and that staff were responsive to their needs. For example, people told us that they could spend their day as they wished and could get up and go to bed when they wanted to. One person told us, "I can get up and go to bed when I want." Another person said, "I don't feel under pressure to rise and go to bed when I want. There are occasions when they might ask me if I mind waiting and I suppose that's when they are under pressure, but that's not that often." A further person told us, "I have not lived here for very long and they [staff] have changed my bedroom twice now because I told them I was not happy." However, some people said that they could not have as many baths or showers as they wanted and that staff did not always answer their call bell in a timely manner when they needed assistance.

The staff we spoke with confirmed that they were not always able to offer people baths or showers to meet their personal preferences. The staff told us that this was because they did not always have time to accommodate for this. On the day of the inspection, we observed mixed responses from staff in relation to meeting people's needs. We saw that some people were responded to quickly to help them with personal care or provide them with food and drink when they needed it. However, we also saw on occasions that people had to wait for assistance with their personal care needs. Improvements are therefore needed to ensure that people's individual preferences in relation to how they want to be cared for are met and that staff are consistently responsive to people's individual needs.

When people first moved into Lincoln House an assessment of their needs had been conducted. This covered areas such as what assistance people required with personal care, eating and drinking and people's social interests. However, although staff were knowledgeable about people individual preferences, we saw that not all of these had been assessed and documented within people's care records. For example, although it was noted where people would prefer to have their meals or their preferences around the food and drink they liked, there was no information recorded such as what time they liked to get up in the morning or go to bed at night, how people wanted to spend their day, whether they wanted a male or female carer or in relation to their bathing preferences. Therefore a full assessment of people's preferences had not taken place.

We also found that some care plans within people's care records did not contain clear guidance on how to meet people's needs or reduce risks of them experiencing harm. It is important that people's care records provide clear guidance for staff about people's current needs to reduce the risk of them receiving inappropriate and unsafe care. For example, a number of people had been assessed as being at a high risk of developing pressure ulcers. Although they were receiving adequate care in respect of this, the guidance in a number of care plans only stated that staff were checking each day for any redness on people's skin. There was no other information on what actions needed to be taken to reduce this risk.

Some people's eating and drinking care plans also did not reflect the care that they required. One person who had been identified as being at risk of not eating did not have a care plan that reflected their current needs in relation to this. In some care records, there was no plan of care to direct staff on what care people

needed. For example, one person had a catheter in place but there was no guidance for staff on how to assist this person with catheter care. Another person was diabetic but there was no clear guidance on how to support this person in respect of these needs. Again, the staff were able to tell us what care was being provided but it was not recorded within people's care records.

We spoke to the registered manager about this. She told us that she was aware that the content of people's care records required reviewing and that discussions were currently taking place with the provider. Therefore, improvements are required within this area to make sure that there is clear guidance for staff to follow on how to provide people with the care they require.

People's care needs were reviewed regularly by the staff and the information was communicated during staff handover meetings. Where changes to people's needs were identified, action was taken to meet these changing needs. For example, a visiting healthcare professional told us that they were regularly contacted by staff when they were concerned about people's health. They also told us that the staff acted on any advice or instructions they gave them in relation to the care of people.

People told us that they had access to activities that complemented their hobbies and interests. One person told us, "There are things going on for me to take part in, but I tend to be happy with my own company except maybe when someone comes to sing to us or whatever. When something is on they'll encourage me to take part but respect my decision." Another person said, "There are things going on here to take part in and there's plenty of entertainment. There's all these things I can tell you about. There's a regular communion by the vicar, we just had Turkey and Tinsel with lovely food, there's exercise to music, a dog visits regularly and we have a resident cat which sits on residents' beds lots of the time. A man brought animals in including a snake and they were sat on our laps if we wanted that. We've got book reading and poetry next month. I really like the reminiscence sessions." A further person told us, "There's plenty of activities and I'll give things a go. Yesterday we had the 'Extend' class and sometimes there might be 15 to 20 people which is very good. I think staff are encouraged to go along. The thing is, the activity isn't just about exercise, it's about talking, laughing and joking which means that the home is putting something on that has multiple benefits."

We spoke with the activities co-ordinator who told us that there were a number of clubs that people could take part in if they wished to. These included a gardening club and 'knit and natter' club. People were also able to access the community if they wanted to and take trips out of the home. They told us that providing people with activities that complemented their own hobbies and interests and to enhance their wellbeing was something the provider was passionate about developing further. The home utilised volunteers to enable them to provide people with a good level of activities and we saw that the activities staff had time to spend chatting with people in their rooms.

People were encouraged to maintain relationships with family and people special to them. One person told us, "If I want something, they'll try to get it for me. My relatives live abroad so they make sure everything is set up for me to speak to them at the right time. They encourage me to keep the contact up." Another person said, "I'll tell you what shows this place cares. On Christmas day, my family decided they would like to spend the day with me. So the home let us a have a private room. My family were all around me. We had our own food and party." A further person told us how the staff had encouraged them to socialise with some of the other residents which had facilitated in them making new friends. They told us, "I was very ill when I first arrived here and I have to say I behaved a bit negatively about everything. I wasn't interested in anything really. Now I know the staff were concerned and they found someone who I got on with and could relate to. That was an important moment for me and honestly turned me round and helped me settle in. I've not looked back from that." We saw that the home provided technology such as the internet and Skype to help

people stay in touch with relatives and friends who were important to them if they were unable to visit regularly.

People told us they did not have any complaints and that they felt confident to raise any issues with the staff if they were unhappy about anything. One person said, "I find if I'm unhappy it's best to speak to those you know and generally it will get passed on." Another person told us, "There's nothing I'm really unhappy about, so even if they asked me I'd have nothing to complain about." A further person said, "I have no complaints and I would tell the doctor [provider] if I did have. I would tell him because I think he would need to know. Yes the staff and manager do listen to me and would help me."

Both written and verbal complaints were recorded by the registered manager. Records showed that these had been fully investigated and that feedback had been given to the person who raised the concern. We were therefore satisfied that people's complaints were investigated and responded to effectively.

Requires Improvement

Is the service well-led?

Our findings

The quality and safety of the service provided was monitored by the registered manager and the deputy manager. This was completed in a number of different ways including audits, annual surveys and analysing information obtained from incidents, accidents and complaints.

We found that some of the current systems in place were not always effective at identifying issues that were discovered during this inspection. For example, there was a shortage of staff to meet people's care needs and preferences in a timely manner. The current system being used to calculate how many staff were required to provide people with care was therefore not effective.

There were audits in place to check that people received their medicines as they should and that care was being delivered appropriately. However, we found that records indicated that some people did not receive their medicines correctly and that some people's risk in relation to not eating and drinking was not being managed well. When we spoke to the registered manager about the issues we found in relation to eating and drinking, she was not aware of them. The registered manager also told us that the provider did not currently conduct any quality assurance checks themselves, although these were shortly to be implemented following the recruitment of a regional manager to the provider's company.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

All of the people we spoke with on the day of our inspection were happy living at Lincoln House and told us that they would recommend the home to others. One person told us, "I would really recommend this care home to others. It's a good place to be." Another person said, "They must all be doing something right, because they make me feel this is my home. I didn't intend it to be and initially didn't want it to be and I remember saying to them, 'Don't you ever dare call this my home', but I now know I belong here. If I had to move I'd be devastated."

Most people told us they felt the home was led well, although four people commented that they did not know who was in charge. One person said, "I don't know the manager but I don't know what else could be done to improve the home. I think they already do everything they can and if anything else needed doing, they'd do it." Another person said, "I have absolutely no idea who is in charge here but I would definitely recommend this home to anyone who is looking for a place to stay."

A number of people we spoke with told us they did not feel that their opinion was asked for about how the quality of the service could improve. However, we saw that a survey was sent to people and their relatives annually, with the next one due to be sent out shortly. We saw evidence that action had been taken following suggestions made by the people who lived there. For example, a request had been made for a post box to be placed in the home so that people could post their own letters and this had been put in place. Regular meetings between the staff and the people who lived at the home also took place where discussions were held about how to improve the quality of care.

The staff we spoke with told us that they had been through a period of instability due to a lack of staff to provide people with the care they needed. They said however, they had seen improvements since more staff had been employed by the provider and that the support given to them when performing their role had also improved. They said that in the main, their morale was good, that they worked well as a team and that they felt listened to. They also said they could raise any issues they had with the registered manager or deputy manager without fear of recriminations.

Staff had the opportunity to develop within the home. Some staff had been promoted into a more senior role to help the nurses with some of their tasks. Staff were also encouraged to participate in qualifications in health and social care to improve their knowledge and skills.

The registered manager told us that she felt the quality of service being provided had improved over the last few months whilst the new staff team was being embedded. This included a new staff structure which was currently being implemented following the recruitment of a number of new staff. She demonstrated that she was passionate about providing people with person centred care and that the home was working hard to implement this. She advised that a number of improvements had been recently made. These included the refurbishment of some communal areas and people's rooms which was on going and the refurbishment of the laundry area.

A new chef had been employed who now prepared food with fresh ingredients rather than frozen and was actively involved in reviewing people's food likes and dislikes. Food moulds had been purchased to enable the cook to make some foods look more presentable for people who required specialist diets. The home had recently retained their five star food safety rating from the local authority.

The home had also been accredited by Norfolk Health and Community Care in the six steps to success in providing high quality end of life care.

The registered manager demonstrated to us that she and the provider were looking to implement further improvements into the home. These included reviewing and improving the information contained within people's care records and staff training and supervision. Other improvements were also being made one of which included the home obtaining a minibus to be used to take people out on outings. This was due to be in place by January 2016.

Staff and healthcare professionals were being included in the upcoming annual survey to widen the number of opinions that were received about the care being provided. A further member of staff was being employed to assist people with their hobbies and interests and ideas were being considered in relation to having a potting shed, chickens and an allotment so people could grow their own vegetables. The registered manager was also planning to include people and their relatives in the training of staff to enhance their knowledge around certain areas such as dementia.

The registered manager had developed a number of links with the community and was looking to increase these. This included links with the local school where the school children would visit the people living at the home. Links had been established with a number of different churches to provide people with support for their individual faiths. Some people living at the home had attended the local harvest festival and had helped to make decorations for the church. Others had been involved in raising money for the local food bank and had completed a walk in the local village in aid of a charity. The registered manager was planning to have a discussion with the local army barracks to see if some joint charity work could take place involving both the home and the barracks.

We have concluded that the home has made a number of improvements recently with the aim of providing people with high quality person-centred care but that further improvements are required to enable them to fully reach this goal.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not protect people against the risks of not receiving their medicines by way of doing all that is practicable to mitigate any such risks. Regulation 12, 2, b.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Risks to people not eating and drinking were not always managed effectively. Regulation 14 1 and 4 a.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality of the service and to mitigate risks relating to the health, safety and welfare of service users were not always effective. Some records in relation to people's care had not been completed. Regulation 17, 1, 2, a, b and c.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff deployed effectively to meet people's needs in a timely manner or to meet their individual preferences. Regulation 18 1.