Anchor Trust

Linwood

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Linwood is a care home that provides residential care for a maximum of 67 older people who may also be living with a dementia type illness. The home is divided into six units across three floors. At the time of our inspection, there were 61 people living in the home.

We previously carried out an unannounced comprehensive inspection of this service on 11 June 2015. At that inspection a number of breaches of legal requirements were found. As result the service was rated inadequate overall and the provider was placed into special measures by CQC. In addition to making a number of legal requirement actions for the service to improve, we also issued two Warning Notices which required the provider to take immediate action in relation to staffing levels and the governance of the home. We undertook a further focussed inspection on 28 September 2015 which found that the provider had taken immediate action to rectify the serious concerns we raised about the service in June 2015. Improvements to staffing levels and the way the home was being managed meant that the provider had complied with the Warning Notices we had issued. We also saw that work was continuing to address the other breaches in legal requirements, although we also identified some new breaches in respect of the way medicines were managed, recruitment processes and the standard of record keeping within the service.

Since our last inspection we have continued to engage with the provider. We asked the provider to submit regular action plans that updated us about the steps they had taken to improve the service. This inspection confirmed that the provider had taken the action they told us they had. Significant improvements to the way the home was being managed meant that the provider had complied with the requirements we had previously issued and we have now taken Linwood out of Special Measures.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A new manager had been appointed in February 2016 and was in the process of registering with the CQC.

Since our last inspection, the service had experienced a period of considerable change. Whilst it was evident that the quality of care had improved, the new leadership of the home now needed to be embedded and sustained. In particular, we highlighted that communication was not always effective across the service and the manager required greater support from those working below him to ensure changes were delivered effectively and consistently across the service.

Each person had a plan of care, however risks to people had not always been appropriately assessed and managed. For example, one person who had recently moved to Linwood had not been properly assessed either prior or post admission. As such staff were supporting this person with only limited information about their needs. We also found that plans in place to support staff to evacuate people in the event of an

emergency did not reflect people's individual needs.

Whilst staff had a greater understanding about the need to involve people in decisions about their care and gain consent, they lacked a good understanding of the Deprivation of Liberty Safeguards. As a consequence people were not always cared for in the least restrictive way.

We found that people were supported to have better choice and control over their care, but that their social needs were not always met. Whilst the service had a programme of activities available, this did not always match people's own expectations and provide them with sufficient opportunities to engage in activities that were meaningful to them. Staffing levels had improved and were now sufficient to provide safe care. People reflected however that they wished staff had more time to sit and chat with them.

Staff felt well supported by the new manager and had access to regular supervision and staff meetings. Whilst staff completed a range of mandatory training courses, not all staff had the necessary experience and confidence to support people living with a dementia type illness.

The service now had good systems in place to safeguard people from the risk of harm. Appropriate checks were undertaken to ensure suitable staff were recruited and staff understood their role in protecting people from the risk of abuse.

The service had a relaxed and friendly atmosphere. Staff were kind and caring towards people and upheld their privacy and dignity at all times. Staff had a good understanding of people's needs and engaged with and supported them effectively.

People were supported to maintain good health and appropriate referrals were made to involve other healthcare professionals in a timely way. Most people told us that they had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet.

The service had taken appropriate steps to address the previous concerns with regards to the management of medicines. There were now processes in place to ensure people received the right medication at the right time.

Systems for monitoring quality and auditing the service had recently improved and were being used to continually develop the service. There were now effective systems in place to ensure that when people raised issues that they were listened to and that complaints were investigated thoroughly.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report. We have also made two recommendations in relation to areas in which the provider may wish to consider making additional improvements to the service.

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.

Risks to people were not always appropriately assessed and managed.

Staffing levels were now sufficient to provide safe care. Appropriate checks were undertaken to ensure only suitable staff were employed.

People were safeguarded from the risk of abuse because staff understood their roles and responsibilities in protecting them.

Medicines were managed safely and there were systems in place to ensure people received the right medicines at the right time.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought people's consent to care and treatment, but were not always proactive in ensuring care was provided in the least restrictive way.

Not all staff had the skills and experience to effectively support people living with a dementia type illness.

Most people had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet.

People were supported to maintain good health. The service made appropriate referrals to other health care professionals to ensure people kept healthy and well.

Is the service caring?

Good

The service was caring.

People had positive relationships with the staff that supported them. The atmosphere in the service was relaxed and friendly.

People's privacy was protected and staff promoted their dignity.

Staff had a better understanding of the importance of involving people in their care and allowing them to make decisions about their day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People experienced a more personalised approach to care and staff had a better understanding about their needs as a whole.

Some people lacked sufficient opportunities to engage in activities that were meaningful to them.

There were now effective systems in place to ensure that when people raised issues that they were listened to.

Is the service well-led?

Requires Improvement

The service was not wholly well-led.

The service had recently experienced significant changes to the leadership of the home which needed to be embedded and sustained.

The new manager was an effective leader, but required greater support from those working below him to ensure improvements were made consistently across the service.

The culture within the service was now more open and staff were responsive to constructive challenge about the way they delivered their roles.

Systems for monitoring quality and auditing the service had recently improved and were being used to continually develop the service.

Linwood

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 was a re-inspection of this service to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 28 April 2016 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because this was a follow-up inspection in which we were monitoring the service against the actions the provider told us they had taken to improve.

As part of our inspection we spoke with 20 people who lived at the home, eight visitors, nine staff, and the new manager. We also reviewed a variety of documents which included the care plans for nine people, four staff files, medicines records and various other documentation relevant to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Linwood. One person was keen to express, "Oh yes, I feel very safe here." People explained that the increased numbers of staff on duty and the way they were treated made them feel safe. Similarly, relatives commented that whilst they had experienced some issues with the overall quality of service at Linwood, they were confident that their family member or friend was "Definitely safe."

Despite people telling us that they felt safe, risks to people were not always appropriately assessed and managed. The home had a policy that risks to people such as skin integrity should be assessed within six hours of admission and that a full care plan must be in place within five days of them arriving at the service. We found that none of these assessments had been completed for a person who had lived at Linwood for more than two weeks. Similarly, the pre-admission assessment for this person had not been fully completed. Staff spoken with had limited knowledge about the needs of this person and as such staff were supporting this person with limited information about the risks associated with their care.

People had personal emergency evacuation plans (PEEPs) in place for staff to follow in the event of a fire. These contained only basic information and did not always accurately reflect the mobility needs of people. For example, one person's PEEP stated 'X (name of person) has been assessed as able bodied and had full capacity. X is able to follow instructions and move to an area of comparative safety with guidance from the staff'. The same person's mobility care plan stated that they used a walking frame and wheelchair for long distances. On a review of multiple care records we found that most of the PEEPs recorded the same generic information and as such were not bespoke to people's individual needs and therefore did not provide the information staff would need to support them safely in the event of an emergency situation.

During the inspection we observed that the door to one person's bedroom door was held open by a piece of wool tied to a shelf in their room. During a fire drill in the morning, we saw that staff removed the wool to ensure the door closed and then replaced it after the drill was over. This indicated that staff were aware that this practice would not protect the person in the event of a fire.

Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff were able to describe safe moving and handling techniques. Staff supported people to move safely from wheelchairs to armchairs using a stand aid. They explained the process to people, telling them what was happening and provided reassurance. When incident and accidents occurred, records evidenced that action was taken to minimise the chance of a re-occurrence. We did note however that the accident report for one incident referred to 'palm to palm' assistance given by two staff when a person was found on the floor. We discussed what this meant with a member of staff who assisted the person. They described manual, physical intervention to assist the person from the floor. The mobility care plan for this person clearly stated that a full body hoist should be used to assist the person up from the floor. The falls risk assessment detailed two falls; one in June 2015 and another in April 2016. The assessment did not include information about another fall that occurred in March 2016 (as documented on an accident and incident form). As such we could not be assured that these risks were always being appropriately managed.

Staff demonstrated to us that whilst they understood safety issues, they did not always follow people's risk assessments to ensure people were adequately protected. For example, the care records for one person highlighted that they were at risk of falls and as such needed to be supervised by staff when mobilising. This did not always happen and we saw that on several occasions it was left to another person living at the service to inform staff when this person wanted to move.

The failure to assess and where possible mitigate the risks to health and safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there were, on the whole enough staff on duty to support people at the times they wanted or needed. Some relatives commented that they thought staffing levels dipped at the weekends. The manager was aware that staff sickness sometimes increased at weekends and was taking appropriate steps to ensure minimum staffing levels were maintained. Staff told us that staffing levels had improved since our last inspection and that they now had time to deliver good care. One member of staff said, "Yes I think there are enough staff, things have improved lately". A team leader told us that the increase in team leaders to provide one for each floor had had a positive impact on the way people were supported.

We saw that the rota reflected the number of staff on duty during the inspection and this level ensured people's needs were met safely. Two people told us that they would like to do more individual activities and appreciated it when staff had the time to spend time talking with them or taking them for a walk. These comments were reiterated by a relative who told us that they visited regularly because they worried that their family member got "Lonely" if they didn't have someone to chat with.

It is therefore recommended that the provider consider reviewing the allocation of staff in line with the provision of more individualised activities.
Appropriate checks were undertaken before staff began work. At our previous inspection a requirement action was set as robust recruitment procedures were not always followed. At this inspection we found that appropriate action had been taken by the provider and the requirement action was met.
We saw criminal record checks had been undertaken with the Disclosure and Barring Service prior to each new staff member commencing work. This demonstrated that steps had been taken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history, written references and job descriptions in staff files to show that staff were suitable to work in the service.
People were protected from the risk of abuse. People said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. We saw that many people nodded and smiled as staff approached them and we didn't observe anyone showing fear or distress with any of the staff.

Staff were confident about their role in keeping people safe from avoidable harm and demonstrated that they knew what to do if they thought someone was at risk of abuse. Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to this. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff had access to up to date policies and procedures and were familiar with them. One member of staff said, "I would report any concerns immediately, it's my duty to do this. I would report to you (CQC) and social services".
Medicines were managed safely. At our previous inspection a requirement action was set as medicines were not always managed safely. At this inspection we found that steps had been taken by the provider and the requirement action was met.
We observed a member of staff complete part of a medicines round. Medicines were clearly labelled, signed for when administered and safely stored. The member of staff did not sign the Medicine Administration

Record (MAR) charts until medicines had been taken by the person. MAR charts were clear and legible. We noted where medicines had been prescribed on PRN 'as needed' basis; staff followed the provider's 'PRN' protocol. This contained information about each medicine prescribed, the reason for administration, the maximum dose allowed and the minimum time between doses. We did note that prescribed creams and lotions were signed for as administered on MAR charts by the team leader who completed the medicines round despite these being applied by care staff and the manager agreed to clarify this process with staff. Medicines were stored appropriately in locked trolleys and medicine rooms. Each floor of the home also had a fridge used to store medicines which needed to be kept below room temperature. Each person had a medicine management care plan which outlined how they liked to take their medicine. For example, before or after food. We observed a member of staff administer people's medicines safely. They signed when the person had taken their medication and disposed of any equipment and sanitised their hands before moving on to the next person. There were no gaps in peoples MAR charts. The member of staff also checked to see if people required PRN medicines such as pain relief medicines.

Daily audits were completed for medicines that were supplied to the home. These included audits of medicines that were not supplied in the monitored dosage system and controlled drugs. Staff received medicines training that included an assessment of their competency to ensure safe procedures were followed.

Discussions with staff and examination of records confirmed that the morning medicines round started at 9am in order that people did not have to be woken or disturbed when having breakfast to take their medicines. We observed that on several occasions the member of staff who was giving people their medicines was interrupted by staff who sought advice and assistance. The medicines round was still in progress at 12.10pm. When the afternoon medicines were being administered we observed that the member of staff wore a tabard that instructed they should not be disturbed whilst giving people medicines. This was not worn when they gave people their morning medicines and we highlighted this to the manager who said that they would remind staff why this was important.

Requires Improvement

Is the service effective?

Our findings

Most people told us that staff involved them in decisions about their care. One person said they did not want to live at the service and were not clear why they could not leave.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff had recently accessed training in this area and demonstrated a good understanding of the MCA. Staff talked to us about the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We observed that people were now better involved in their care and that staff routinely asked for their consent before supporting them. We found that the service had made appropriate referrals to the local authority in respect of people they had assessed as potentially being deprived of their liberty.

At our inspection in June 2015 a requirement action was set as staff had not always taken appropriate steps to gain consent from people. At this inspection we found that steps had been taken by the provider and the requirement action was met. We found that one person had a detailed mental capacity assessment and a best interest decision record that showed that a range of people including the persons social worker, GP and staff at the home had been involved in the decision making process about their care and treatment at the home.

Whilst staff were now clear about the importance of involving people in decisions about their care and treatment, staff, including team leaders did not always have a good understanding about DoLS. We raised concerns about one person who was potentially being deprived of their liberty without lawful authorisation. During the inspection this person repeatedly requested to go home and staff failed to give them an accurate account about what was happening to them.

We observed this person attempt to leave the home via the main front door. The person was heard to say, "Someone's coming to take me home today". A member of staff distracted the person who then stopped attempting to leave the home. The person sought assurances from the member of staff that someone was coming to take them home later that day. The member of staff confirmed this to be the case. We spoke with this member of staff and they told us that they did not know anything about the person and that they did not know if someone was coming to take the person home. On several further occasions we observed the same person inform staff that they wanted to leave the home and became anxious as they told staff "You aren't telling the truth."

We looked at the care records for this person and found that there was a completed mental capacity assessment in place and best interest form used to record meetings with the person's power of attorneys and the manager. These documented that the person experienced short term memory impairment and was not aware of the immediate dangers such as crossing the road if outside of the home. The manager had made an urgent DoLS application when they were admitted to the home, but this had not been followed up. We spent time with the person and talked about aspects of their life and their experience of living in the home. They confirmed that they did not want to stay at the home and explained their reasons why. Information within the person's assessments and other documentation on file was conflicting and it was not clear whether the person lacked the mental capacity to consent to stay at the home. We therefore required that the manager make an immediate safeguarding referral to the local authority in respect of this person. The manager confirmed within 12 hours of the inspection that this had been done and the person has since been appropriately assessed and arrangements have been made to safeguard their legal rights.

We also overheard another person asking to go home and a staff member telling them that they would drive them home that afternoon. Again this was not the case. The person had been a resident at Linwood for a number of years and there was no plan for them to leave. We raised this with the manager who showed us that a standard DoLS application for this person had previously been made and was awaiting assessment by the local authority. It was also evident in this person's care records that their medical condition had recently deteriorated. Whilst there was no concern about this person's care, staff had failed to recognise the need to update this authorisation request when the person's needs changed and inform the local authority that the person was now requesting to leave the service.

It is recommended that the provider take additional steps to ensure care and treatment is always provided in the least restrictive way.

Staff received support and training that helped them fulfil their roles and responsibilities. New staff undertook a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. In addition to formal learning, new staff also shadowed more experienced staff. One staff member told us that their induction had included topics such as moving and handling, mental capacity and safeguarding. They also told us that they had to complete a competency test at the end of each topic. The manager confirmed that he reviewed the test scores to assess staff knowledge and ensure their learning was effective.

Following induction, staff had access to an ongoing programme of training. One staff member told us, "I have done lots of e-learning training such as safeguarding, MCA and dementia." Staff said that they found the training useful, with one staff member commenting that it was "Very good." People said they had confidence in the staff that supported them, but we noticed that some staff were not always confident in supporting people when they became agitated or confused. We discussed this with the manager who had already identified a need to strengthen the staff knowledge of supporting people with a dementia type illness.

Staff said that they now felt well supported by the management team. For example, one staff member said, "I have regular supervision with my team leader and appraisal with the manager. It's a good place to work. We are given tasks that help with our development. You get support that you want." Similarly, another staff member told us, "I have supervision every six weeks and it's useful. If something worries me then I can bring it up there."

Supervision records showed that all staff had received supervision in the last month. Records of these

discussions showed that staff now had the opportunity to talk about their worries or concerns. For example, one staff member had been involved in an incident with a resident and was able to discuss their concerns with the manager in supervision. We could see that issues raised were documented and a suggested course of action was laid out for staff members following this.

People said that they enjoyed the meals provided. One person said, "The food is lovely. It's important to us. If you want anything in particular they try and sort it for you". We saw that daily menus were on display and people confirmed that they were given a choice at every meal.
Whilst we saw evidence that people's specialist dietary needs were managed, one visitor told us that they thought the variety available to people with a vegetarian diet could be improved.

People's nutritional and hydration needs were met. People's skin looked visibly hydrated and we observed that staff supported people to drink fluids throughout the day. Care plans included information about people's dietary needs and the support required. Weights were recorded monthly or more frequently if assessed as being at risk. Where people required referral to specialist services i.e. speech and language therapy (SaLT) or the dietician this was managed in a timely way. We observed that people received meals such as soft diets or thickened drinks in accordance with their care plan.

People were supported to maintain good health. People said that they were happy with the medical care and attention they received. One person also confirmed, "I can see a doctor if I ask." Staff demonstrated that they understood the importance of making prompt referrals to appropriate professionals if they had concerns about any aspects of a person's health. Care records documented that people attended regular health checks with their doctors, dentists, opticians and chiropodists. We noted that advice and guidance given by these professionals was followed and documented.

The physical environment of the home was accessible to people. Wide corridors and handrails enabled people to mobilise safely around the service and bathrooms provided adaptations which facilitated independence. There was ongoing refurbishment at the time of our inspection with kitchen facilities in one of the units being upgraded. It was however noticed that paintwork throughout the service did not clearly distinguish areas such as toilet and bathrooms.

Good

Is the service caring?

Our findings

At our inspection in June 2015, we found that people were not always treated with kindness nor were they sufficiently involved in making decisions about their care. We therefore set two requirement actions for the provider to make improvements in these areas. At this inspection we found that appropriate steps had been taken by the provider and both requirement actions were met.

People told us that they had good relationships with staff. For example, one person told us, "The staff are kind and helpful" and another said, "The staff are very good here and very respectful." Similarly, the visitors we spoke with were also keen to tell us that staff were "Very good" and had a good rapport with their family member or friend. One visitor told us, "There are always staff in close attendance and they treat people with courtesy, good humour and affection." Each person had a member of staff allocated to them who was responsible for having oversight of their overall needs, called a keyworker. Both people and their representatives consistently told us that they found their keyworkers to be "Excellent," "Lovely" and someone who really "Looked after" them.

Staff treated people with kindness and compassion. Staff were observed chatting and laughing with people when they were sitting having breakfast. One person appeared reassured and content when a member of staff gave them a hug. Another member of staff was seen sitting with a person, stroking their hand and talking to them about their family and life experiences. The person told us that they had recently fallen and as a result this had affected their confidence. They said that staff understood this and had regularly offered reassurance and emotional support.

People benefitted from the steps taken to involve them in their care. Staff had spent time getting to know people, their histories and their interests and as such were able to deliver care in a way that reflected people's needs and choices. Staff demonstrated an understanding that supporting people effectively was about providing care that was personal to them. For example, staff were seen assisting three people to sit together. The people told us that they had become friends since living at the home and that staff understood that their friendship was important to them.

People's privacy was respected. We observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. People had the option of locking their bedroom doors if they wished to and also had lockable drawers in their rooms.

When people required personal support we saw that this was provided discreetly and in a way that upheld people's dignity. Staff demonstrated they understood the importance of building relationships and trust with people before offering care. For example, one staff member told us, "I always ask before entering someone's room. It is important to speak to them, I ask them how they are today and how they slept. I always ask them before I provide personal care."

Throughout the inspection we noticed that staff approached people in a patient and sensitive manner. For example, one person who was living with dementia became confused at lunchtime. We observed staff

engaging with this person and talking to them about their food in order to remind them to eat, in an empathetic and caring way.

People had been supported to personalise their bedrooms and many were keen to show us how they had made their room their own. Relatives told us that since the changes in management had occurred, greater attention had been paid to creating a more homely environment. Some communal areas were in the process of being refurbished and the manager was planning to get people more involved in making decisions about how they wanted these areas to look.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in June 2015, we found that people had not always received support in a person centred way and we set a requirement action for the provider to improve. At this inspection we found that people were receiving a more personalised service and that this requirement action had been met.

People had choice and control over their daily routines. For example, people told us that they could get up and go to bed when they chose and spend their time as they wished. We observed that one person had chosen to go back to sleep after breakfast and did not wake again until just before lunch. We saw that staff offered them a choice of lunch or another breakfast when they came to the dining room. A conversation with this person's representatives highlighted that this was a usual routine for them which the service always respected.

Each person had a plan of care that provided information about people's support needs. The manager informed us that they were still in the process of reviewing and updating all care plans to provide a better overview of people's care needs. As such we found that these documents were in various stages of completion, but that overall people were receiving a more personalised approach to their care than at previous inspections. For example, the care records for one person highlighted that the person used to work in a care setting and wished to be involved in helping people. Staff were all aware of this information and throughout the day we observed this person being supported to make tea for other people and staff.

Some people who were living with dementia had a document titled 'My living story' in place. These gave staff information about people who were important to the person, their past memories, hobbies and interests, and preferences. Staff confirmed that the information within these helped them to understand the whole person before they lived with dementia and as such enabled them to support the person more effectively.

Where people had specialist medical or healthcare needs we saw that they had a specific care plan in respect of this. For example, staff talked to us about the support some people needed to maintain adequate nutrition and hydration and the steps they took to facilitate this. When we looked at the care records for these individuals, we found that the guidelines in place matched what staff told us.

People did not always have access to activities that were meaningful to them. We received mixed feedback about the activities available. We found that whilst some people were engaged in the activities on offer or happy pursuing their own interests, other people told us that they were "Bored." Two representatives said that their feared their family member was "Often lonely." We read in care records that some people were highlighted as being at risk of 'social isolation' and yet there was no care plan which explored the activities the people themselves said they would like to participate in.

The service particularly lacked appropriate social opportunities for those people who had greater levels of capacity. One person who required only physical support was emotional when talking with us and commented, "I could do so much more than I do. I enjoy the quizzes, but I would love to go out more. I have

different needs to many of the other people that live here and as such I do get bored being in my own company." Similarly, the relatives of another person told us "We don't find our family member doing anything and they are quite able to respond. They sit here all day and do nothing."

The service employed two dedicated activity staff and it was clear that the home did offer a programme of activities and the manager explained that efforts were being made to further improve this area. For example, on the day of the inspection we observed one to one games in the morning and then people went into town for a group outing in the afternoon. A group activity that we observed in the morning was lively and well attended. Eight people out of the ten on the top floor attended. Staff were engaging with people who were all smiling and evidently enjoying each other's company. Music was playing and people were dancing and singing along.

The timetable showed that on other days, activities included light physical exercises, reminiscing games and arts and crafts activities. Staff also told us that two people had recently been supported to visit a local pub and enjoyed a hog roast. The lack of an assisted vehicle however, meant that access to external activities was limited for those people with mobility needs.

One of the activities co-ordinators informed us that the service had recently purchased a tablet computer as a way of developing activities. At this stage however, technology was not being used to its full advantage. For example, none of the people we spoke with had heard about using technology to have face to face contact with family members who were unable to visit them. When we highlighted this possibility to them, one person replied, "That would be wonderful. My son lives abroad and if I could see his face and speak to him it would be wonderful."

The failure to design care which reflected people's preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff now felt better valued because their views were listened to and any issues raised were handled in an open, transparent and honest way. People were given information about how to make a complaint and there was evidence that when they did, their concerns were listened to and investigated. The home's complaints procedure was readily available in the home and people their representatives told us that they now felt their concerns were being dealt with.

The manager kept a file of the complaints received and action taken. There was evidence that complaints had been acknowledged, taken seriously and investigated with people receiving a written response.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in September 2015 we found that the home had significant failings in respect of the way it maintained accurate records and as such a requirement action was set. At this inspection we found that the quality of record keeping overall had improved across the service and the requirement action was met. The manager was clear that measures to further improve the quality of record keeping was still on their own action plan for the service.

As Linwood had been in Special Measures since June 2015, the provider had instigated additional management oversight at Linwood. They also supplied us with regular updates that highlighted their progress against an official action plan of required improvements. Following a period of interim management, a new manager was appointed in February 2016 who is currently undertaking the process of applying to become registered with the CQC. More recently a new deputy manager had also been appointed. It was evident that improvements had been made to the quality of the service provided and further plans for positive change had been identified. The service now required a period of stability for these changes to be embedded and sustained.

The feedback received from people, their representatives and staff was that the new manager had so far been effective in their leadership of the service and that they had confidence that Linwood was now going in the right direction. We observed that people had a positive relationship with the manager and that they were reassured when he spoke with them. One person told us, "The new manager is very good; you can tell he is making real changes here." People's representatives were also optimistic about the future of the service and felt that the home was now "Beginning to turn the corner." Relatives highlighted that the management of Linwood was now "Noticeably more visible" and one told us, "He genuinely seems to react to the concerns we've raised and get what we are saying."

The new manager had been proactive in his engagement with people and their representatives. We found that he had held a number of formal as well as informal meetings as a way of engaging them in the process of change. Relatives highlighted the value of this engagement, but raised some concerns that communication was not always as effective throughout the whole service. Several family members and friends told us that communication about medical appointments in particular did not always work well and that they felt the need to keep involved in this area to ensure people attended appointments at the right time. We also observed that some team leaders did not have adequate oversight of their areas of responsibility and this led to confusion for people. For example, at lunchtime on one floor we noticed that three staff members were all offering different support to one person who was anxious and as a result this caused them additional frustration. Similarly, we noticed that whilst individual staff were maintaining records of what people had to eat and drink, no one had assumed overall oversight to ensure this was sufficient on a daily basis.

Staff told us that they believed the service was now well led and that they felt both motivated and empowered by the new manager. One staff member told us, "I am so happy to come to work every day now" and another said, "Both the manager and the deputy manager now challenge staff practices and remind us

about what we need to do." At our inspection in June 2015, staff morale was low and staff felt unsupported in their roles. At this inspection, it was evident that the culture was more open and staff felt well supported. Staff told us how the manager operated an 'open door policy' and that they now felt confident that the things they raised would be acted on.

Staff told us that in addition to ongoing support they received regular supervision with their line manager. We saw in staff records that this process was now being used to develop staff practices and learning. Similarly, frequent staff meetings were being used to encourage staff to reflect and improve the way they carried out their roles. For example, we saw that one meeting had been used to discuss the way medicines were administered to ensure all staff were clear about what was expected of them.

People were afforded greater protection from the introduction of better systems to monitor the quality of the services provided. In addition to provider level monitoring of the service against a specific action plan, the manager also conducted regular audits of areas such as medication, falls, and infection control. Following the reviews of such areas we saw that the manager had taken appropriate steps to improve the quality of care. For example, we noticed that the number of falls occurring within the home had reduced each month.

Incident and accident reports were completed as necessary and the manager appropriately reported notifiable incidents to the CQC in accordance with the Health and Social Care Act.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care of people did not always reflect their preferences especially in relation to their social needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way to service users because risks to health and safety had not been appropriately assessed and mitigated.