Mrs Rita Baker and Mr Mark Baker

Linden 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

Overall summary

This was an unannounced inspection and took place on 05 and 08 May 2015.

At our last inspection on 16 December 2013 we found the provider was meeting all the expected standards of care.

Linden House provides accommodation for up to 21 people who require nursing or personal care. Care and support is provided to older people, some of whom are living with dementia. The home is an older style property consisting of two floors. Building work is underway at the back of the property to provide a further lounge area, extend the dining room, toilets, a wet room and four en-suite bedrooms. These beds would be used to accommodate people who were currently sharing rooms. At the time of our inspection there were 21 people living in the home.

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

Summary of findings

People and their relatives felt safe with the support they received form staff at Linden House. Staff received training in safeguarding adults and could identify abuse and knew how to report this. Recruitment processes were robust and included appropriate checks to ensure staff were suitable to work with older people. People and staff told us there were sufficient numbers of staff on duty.

People did not always receive their medicines safely. Storage of medicines was not safe. 'As required' medicines did not have clear guidelines when they should be given or a care plan detailing steps to be taken prior to this medicine being given. Staff were not assessed as to their competency to administer medicines. One medicine's instructions were not adhered to when it was administered.

Overall the home was clean and people told us their bed linen was changed regularly. There were some areas where cleaning was compromised due to age of equipment and maintenance of the building. There was a risk of infection as connecting doors to the laundry and kitchen were left open. Storage of some cleaning equipment was against control of infection guidelines.

Staff received appropriate levels of training to enable them to deliver care. When staff began working in the service they completed an induction programme and worked alongside experienced staff before they could work unsupervised. Staff told us they did not receive regular supervisions.

The registered manager and staff did not have a full understanding of their responsibility under the Mental Capacity Act. Two applications had been made for DoLS authorisations without mental capacity assessments carried out as part of the process. Mental capacity assessments decisions were not documented.

Assessments of people's needs were made before they moved into the service. Care plans and risk assessments were written based on people's identified needs. However, not all care plans contained sufficient guidance to meet people's specific needs. People told us they were involved in reviews of their care plans but the documentation in their care records did not reflect this.

People and their relatives told us the food was good and they enjoyed the choices of meals available. Where people required a special diet and supplements this was recorded and staff monitored their weight and how much food and drink they had.

Access to healthcare for people within the home and to hospital and dentist appointments was good. Health care professionals told us they were involved in supporting people with their health needs and the provider supported them.

People and their relatives had good relationships with staff and said how caring they thought staff were. They said they were able to speak to the staff or registered manager about any problems they had and know that these would be dealt with. Staff showed respect for people. However, we observed where people were receiving treatment from the chiropodist and having their hair done by the hairdresser, these were happening in rooms which had their doors open. This meant people's privacy and dignity was not being upheld.

There were few activities happening for some people on the days we inspected. People and their relatives had commented on this through feedback questionnaires and had requested more activities. The provider had responded partly to this but there were still a number of people we saw who were not actively engaged in activities during our visit.

The provider engaged an outside specialist to carry out an audit of the quality of the service. This audit had identified areas for improvement which the provider had not responded to with an action plan. Other monitoring systems for health and safety and maintenance checks were occurring regularly.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of this report.

Summary of findings

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.

Medicines were not stored appropriately and 'as required' medicines were not managed effectively. Staff were not assessed on their competency to administer medicines.

People were not always protected from the risk of infection as some infection control processes and practices were not followed. Some older equipment and areas of the home required maintenance to improve hygiene standards.

Staff were aware of how to raise a safeguarding concern and were recruited and trained appropriately. Risks were managed within the care planning system.

Is the service effective?

Requires Improvement

The service was not always effective.

Care plans did not include detailed information on how to meet some people's specific needs. There were no care plans to manage persistent infections.

Mental capacity assessments were not completed as part of Deprivation of Liberty Safeguards. Other mental capacity assessments were not recorded appropriately.

Whilst staff received suitable training to deliver care, they did not receive regular supervision to discuss their performance or people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives were happy with the care they received.

People were encouraged to express their views and were involved in decisions about their care. This was not reflected in their care records though.

Staff treated people with respect and asked for consent before offering care.

People's privacy and dignity was not respected when they were being supported to see the chiropodist or the hairdresser.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People said they were involved in planning of their care but the care plans did not show how they had been involved. People's care plans were regularly reviewed.

Summary of findings

Staff knew what people's personal preferences, choices and likes and dislikes were. People told us they wished there were more activities for them to enjoy both in the home and in visiting the local community.

People knew how to make a complaint or compliment but the information was not easily accessible for them.

Is the service well-led?

Requires Improvement

The service was not always well led.

A quality audit system was in place that did not reflect the new regulations. The provider had not completed an action plan to effect changes suggested in the audit.

The registered manager was approachable and visible by assisting people regularly. Staff said they felt supported but did not receive regular supervisions.

There was a positive culture within the service and staff understood this. There was a member of staff who was a dignity champion and supported other staff to promote respect for people they supported.

Linden 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 05 May 2015 and was unannounced. The inspection was carried out by an inspector and a specialist advisor whose area of specialty was in the care of older people.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The form was completed and returned to us within the requested timescale. We looked at the information included in the PIR along with other information we hold about the service. This included notifications of deaths, incidents and accidents that the provider is required to send us by law. We spoke with a commissioner before we visited the service.

During our inspection we spoke with four people who used the service, four relatives who were visiting, seven staff including the provider, administrator, care staff, chef and housekeeping staff. We observed the lunch time meal and observed medicines being administered. We looked around the service including shared areas and facilities. We looked at the care and support plans for seven people and the staff files for five members of staff. We also looked at other records such as accident and incident records, records for monitoring the quality of the service, complaints records and health and safety records.

We spoke with two visiting health care professionals. One was a chiropodist and the other was a GP. We made a telephone call to a care manager for their views on the service.

We last inspected Linden House in December 2013 and there were no concerns at that visit.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Linden House. One person said, "Staff make me feel very safe." Another person said, "The staff know what they are doing and would not let anything happen which would make me feel unsafe." A relative said, "One of the things that helped us decide to place mum here was knowing that she would be in a safe place, surrounded by people she liked and staff who knew how to care for her." Another relative said, "I know dad won't come to any harm here as staff are quick to refer to the GP if they notice a problem."

The provider's medicines policy had not been reviewed or updated and contained minimal information about processes for the safe storage, administration and monitoring of medicines. It did not include references to up to date guidelines such as; National Institute for Health and Care Excellence (NICE) managing medicines in care homes. The policy did not detail how the medicine trolley should be secured after it's use. There were no instructions for staff on the secure storage of medicines and keys to medicine trolleys and cabinets within the home.

Medicines were not stored securely. The medicines trolley was kept in an open room where it was not secured to the wall. Staff and visitors could access this room and the medicines keys were kept in another area that could be easily accessed. On the second day of our inspection the provider showed us the medicine trolley was securely attached to the wall and arrangements had been made for the security of the keys for medicines. Controlled medicines were kept securely but not in an approved cabinet. The key was also not held in a secure manner. The provider was not compliant with legislation concerning the safe storage of controlled drugs as detailed in the Misuse of Drugs (Safe custody) Regulations 1975.

Medicines were not disposed of promptly. One person's medicine prescription had been changed but the previous stocks had been retained. Staff said this was just in case it was needed again. This medicine had been removed from the person's medicine administration record (MAR). NICE guidelines states unwanted medicines should be disposed of promptly.

Staff were not assessed in their competency to administer medicines safely. Staff told us they had received training in the administration of medicines but said they were not assessed to see if they were administering medicines safely. Competency assessments are an integral part of medicines safety as outlined within the NICE guidelines.

Care records did not contain care plans or protocols for the administration of 'as required medicines'. People were at risk of not receiving enough, or receiving too much pain relief. Four people's care records referred to them having pain of a severe and enduring nature. There were no pain care plans in place which could assist staff to recognise and respond to signs people were in pain. This was particularly important when people have cognitive impairment and cannot verbalise when they are in pain. Six people's MARs had 'as necessary' (prn) medicines prescribed.

Specific instructions for the administration of one medicine were not followed. One person was prescribed a particular medicine which the MAR stated should be given at 08:00. This product has specific instructions that it should be given on an empty stomach with just water and no food or other fluids to drink for an hour afterwards. The MAR showed it was given at the same time as other medicines and when the person ate their breakfast. Staff told us they were unaware of these instructions.

The failure to ensure medicines were safely managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of infection. The laundry room was next to the kitchen and the door between the two areas was open on both days of our inspection. This meant the kitchen was not protected from any airborne contaminants which may have come from soiled laundry. The two grey mops for washing the kitchen floor were kept in the laundry room. One was damp and the other one was very wet. Both were stored mop head down, one directly on the floor and the other in a bucket. This is contrary to Department of Health guidance on the control and management of infections.

There were cracked floor tiles around the door of the kitchen. It would not have been possible to clean this floor to an acceptable infection control standard. Some commodes in people's rooms had been replaced. Six older commodes showed signs of wear on the sides and underneath the seats which meant these could not be cleaned to an acceptable level of infection control.

Requires Improvement

Is the service safe?

We observed staff taking yellow bags to the laundry room without wearing disposable gloves. Staff told us they were carrying daily non-soiled linen and laundry in the yellow bags. Department of Health guidance suggests that white bags should be used for normal laundry and red bags should be used for soiled linen and laundry. Yellow bags signify soiled waste products which may be confusing to staff and visitors seeing these being carried without staff using appropriate personal protective equipment. Staff were unaware of this guidance.

The failure to protect people from infection is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "the home is very clean and I have my bed linen changed two or three times a week. They keep my room spotless." A relative said, "It may not be the most modern clinical care home but I can say it is a lot cleaner than the last home dad was in. We always see staff tidying up and cleaning as they go."

People and their relatives had mixed views on the level of staff on duty. One person said, "I don't want to use my call bell as the staff are rushed off their feet." Another person said, "we could do with some more staff sometimes as I have had to wait for someone to come to me for quite a long time." A relative said. "There seems to be enough staff but they always seem to be busy." One member of staff told us they did not feel there were sufficient staff on duty. They said, "I like to speak to people whilst I am supporting them and will always stop in the lounge to chat with people when they ask me for something. Unfortunately I feel that I have to rush this as other tasks take up my time."

The provider rostered staff on a daily basis to meet the identified needs of people. We checked staff rosters and saw there were four staff assigned to each shift and two care staff at night. However, one of the names on the roster for each day shift was that of the registered manager. On the first day of our inspection there were three care staff on duty. The provider had put their name down on the roster to provide hands on support for both shifts that day. They were not in the building until the afternoon and had not arranged for a member of staff to cover their shift. Staff told us the registered manager always worked shifts providing hands on support. When the manager was engaged in their managerial duties there were no extra staff to provide care. This may have left people without sufficient levels of staff support.

The provider managed protection of people by ensuring staff had received training in safeguarding older people. Staff identified types of abuse and were aware of how to report concerns. One member of staff said, "I would have no hesitation in reporting anything I saw to the provider." The provider's policy followed the Southampton City Council joint policy and referred to their procedures for reporting concerns. The registered manager demonstrated how they had managed a recent incident they had reported to safeguarding. A member of the safeguarding team us the provider had responded appropriately to their report following their safeguarding visit. This issue was now closed due to the appropriate handling of the concern by the provider.

The provider's recruitment processes were robust and appropriate. Application forms gave an account of the person's employment history and their education and occupational achievements. Two references had been obtained, one being their last employer. Relevant checks were completed to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. This included a Disclosure and Barring Service (DBS) record checks. Staff confirmed with us that they did not start working in the home until the provider had made the appropriate checks.

People's needs were assessed when they moved into the service. Most risks to people were recognised and assessed. When a risk was identified a care plan was created to advise staff as to how the risk should be managed. For example, one person's care plan identified the support they required to walk. The risk assessment identified painful joints may hinder their ability to walk. The identified action to lessen the risk was to review their pain management and include guidelines in giving pain medicines in the care plan. People had been identified as having care and support needs relating to moving and handling and the provider ensured equipment such as hoists were available. Moving and handling risk assessments were in place for people who required them. Staff told us they had received training in moving and handling, including the effective and safe use of equipment used to assist people. This included when they needed to mobilise or transfer from, for example, bed to chair.

Requires Improvement

Is the service effective?

Our findings

People told us they felt supported by staff. One person said, "the staff are ever so helpful, I don't wish for anything." Another person said, "I am involved in my care plan and staff have heard what I've said and put it in there. This means I don't have to tell new staff what my needs are." Another person said, "The manager and staff know me so well. They know exactly what I like to eat and drink and how I want to be helped. They all know this as I don't have to tell them this now." One relative said, "Every time I visit here it is like I am visiting Mum in her own home. As a relative, staff involve me in a lot of things and I know she gets the best care available." Another relative said, "the management and staff are very pro-active over all aspects of care, particularly around health care."

However, we found not all care records had a detailed care plan which could provide staff with appropriate guidance about how to meet people's specific needs. One person's records showed they had a history of depression but there was no care plan for this. The person told us about various treatments they had received and a history of their care in hospitals for depression. Their daily records showed they had a sore mouth on 02 May 2015 but there was no care plan or record of a referral to a doctor.

Arrangements were not in place to respond appropriately and in good time to people's changing needs. Three other people's records showed they had experienced severe urinary tract infections on more than three occasions in a year. These can cause a lot of pain and distress to older people. There were no preventative care plans to assist staff to observe signs of urinary tract infections; such as reduced appetite, reluctance to drink, general feeling of being unwell and cognitive changes as well as pain and raised temperature. With this care plan in place staff could recognise when people's condition changed and arrange medical treatment at an earlier stage.

The failure to ensure people received all the health and personal care they required is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and staff lacked understanding of their responsibilities under the Mental Capacity Act 2005 (MCA). The MCA exists to protect people who may lack capacity to make certain decisions and to ensure that their best interests are considered when decisions that affect them are made. For example we saw for one person a section in their care record about their health needs which stated, 'has short term memory loss.' This was further confirmed in the section on cognitive development which stated, 'lacks capacity due to a degree of confusion and memory loss.' There were no specific records of the person's capacity to make decisions. A mental capacity assessment had not been carried out to ascertain if they could make certain decisions about their care. Where people had been assessed as lacking capacity to make decisions their records did not show how decisions should be made to meet the best interests of the person.

The provider had applied for Deprivation of Liberty Safeguards (DoLS) authorisation on behalf of two people. The records did not contain evidence of the mental capacity assessments to support these. We saw some people had bed rails and movement pressure mats in their rooms, which were there to alert staff that the person was moving in their room or had fallen out of their bed. In each of these instances a mental capacity assessment should have been undertaken to determine if they had the capacity to consent to these measures being put in place. There were no records that these measures were in place and it was in the person's best interests to protect them.

The failure to follow the principles in the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they did not receive appropriate levels of supervision. One member of staff had begun working in January 2015 and told us they had not yet had a supervision. Another member of staff said they had two supervisions since October 2014. We looked at the supervision records of four members of staff and found that there were long gaps of three months or more between supervisions. The provider's policy said staff should have two monthly supervision. Without regular supervisions poor practices and performance may not have been identified and addressed in good time.

A supervision monitoring system was introduced in 2015 and this identified the main gaps in supervisions had occurred during 2014. Three members of staff told us they felt supported by the registered manager and they felt confident in speaking to them at any time. Staff received appropriate training to enable them to perform their duties. The registered manager maintained records of all

Is the service effective?

training staff received. One member of staff told us, "my induction training gave me the basic skills I needed and I shadowed an experienced member of staff for three weeks observing how they worked with people." They said they had received other training, which was confirmed by training records. Staff were able to access further professional qualification training such as a diploma in adult social care level two of the Qualifications Credit Framework (QCF).

Staff were knowledgeable of people's needs and how they liked to be supported. For example, we saw staff at the mealtime sat beside people encouraging them to be independent when eating. One member of staff asked a person if they wanted help with their meal. They waited for the person to answer and then sat next to them and placed food on their spoon. The person was able to feed themselves. One person did not want the menu options and a member of staff offered the person three choices of food which they knew the person liked.

People told us the food was healthy and nutritious. One person said, "the food is lovely I really like the roast dinners." The chef told us a menu for each week was available and they had a rolling four week menu. People could make changes and could make choices of foods they wanted on the menu. Each day there was a main meal suggestion and an alternative if people preferred it. If people decided they did not want either meal, they could have an omelette, salad or something else if available. People ate their meals together, although the tables were quite close to each other. This made it difficult for some people to walk around the dining room to their table. Food was served quite quickly and people did not wait long to receive their meals. The food was hot and looked appealing and comments we heard were all positive about the quality of the meal.

The chef told us they were aware of people's individual dietary needs and their likes and dislikes. This was evident by a chart in the kitchen highlighting which people required special diets or supplements. Food and fluid intakes were recorded for people who required this to be monitored due to health concerns.

People were supported to maintain good health and the provider had a good relationship with their local GP surgery. A relative told us, "I am so happy my mum is here. The staff respond to her and actually know her so well that they identify when she needs to see the GP before she becomes unwell." People were visited in the home by their GP and district nurses. A GP told us, "I have no worries about the home, the manager is excellent and the staff are good, they always carry out my instructions." We spoke with a community matron who was visiting the home for the first time. They told us they were pleased with the communication and the support they received from the staff was good. One person told us they had been to their dentist recently as they needed to have a new set of dentures made.

A visiting health professional said, "Care staff provide a high standard of end of life care with the support of the district nursing team. Care staff monitor pressure areas and do regular weight and body mass index (BMI) checks to identify any problems with weight loss." Care records showed these checks were completed consistently and were up to date.

Requires Improvement

Is the service caring?

Our findings

One person told us, "The staff are very helpful. They really do look after us well." Another person said, "I couldn't wish for better care, much better than where I was before. Staff are really friendly." A relative said, "The staff really are the best carers we have come across. They treat our relative with the same friendliness and compassion that they show to us." Another relative said, "the care of my Aunt is conscientious, thorough and compassionate. Staff actually listen to what she is saying."

On one day of our visit, the chiropodist and hair dresser were visiting the home. They both worked in rooms leading on to the lounge and dining room. The doors were open whilst they were working with individuals and anyone could see what was happening. People were not asked if they wanted the door closed. Staff began hoovering the dining room after the lunch time meal had been served. Some people were still sat at the table eating their dessert and one person appeared to be upset by the noise of the hoover. These were examples of where people's privacy and dignity had not been fully respected.

We did see some examples of good interactions where people were treated with dignity and respect. One member of staff knelt beside a person so that they were at eye level and could hear what the person was saying. Staff respected people's privacy by knocking on their bedroom door and waiting for a response before entering their room. A member of staff was a dignity champion (a dignity champion supports and encourages staff to treat people with dignity and respect) who told us they had introduced signs to place on bathroom doors when personal care was being given so that other people or staff would be aware someone was using the bathroom. There were also references within people's care plans regarding the maintenance of people's dignity. Staff interactions were friendly and warm towards people and we heard several light hearted conversations and laughter.

The home had a relaxed and welcoming atmosphere, which was something people, visitors and professionals were keen to tell us about. This was a busy home with lots of visitors. There were also building works taking place at the rear of the property. Whilst this was noticeable, by sheeting put up in a connecting doorway to the new extension, this was not disruptive to people. One person said, "I have a very good relationship with the manager and the staff. They are all so approachable and nothing is too much trouble for them." One person still visited the home on a daily basis after his wife, who had been living in the home, passed away. He helped with gardening and enjoyed talking to people in the home.

Staff told us they liked to treat people as they would wish to be cared for themselves. One senior member of staff said, "We are looking at some learning opportunities for staff so that they can feel what it is like to do things for people. Especially around eating, dressing and moving. If they experience these things being done to them, they can use that when working with people." We observed how staff assisted people at meal-times encouraging them to eat independently and asking them before providing them with support to eat their meal.

One relative told us, "There are no secrets, we can visit mum at any time and there is no difference in how she is treated. We really are grateful that we have a good relationship with the manager and staff." Another relative said, "I have enjoyed visiting my sister in law so much that I wouldn't mind coming here myself if I needed to be cared for."

One relative told us, "It's not the most luxurious care home but it is homely. I know mum is safe here and is receiving the best care staff can give her. I go home after visiting her knowing that she is safe and well cared for. I do not have to worry about her." A commissioner told us, "They have great respect for the people they care for and treat them with dignity. The home is always calm and peaceful. People are well presented and interact well with each other and staff."

People were encouraged to express their views through a number of ways. The registered manager engaged people in conversations on a daily basis and listened to what people said. There were also suggestion boxes where people could leave comments or suggestions for things they could do. We saw where the registered manager had received a comment about an activity a person would like to engage in. We saw in the calendar of activities where they had planned for this activity to happen. People told us they felt comfortable to tell staff and the manager about things they would like.

Is the service responsive?

Our findings

One person told us, "I asked to see a dentist last week and the staff have arranged for me to go next week and will support me to go." Another person said, "I can talk to [registered manager's name] about any problems I have. He always listens and sorts things out for me." A relative said. "Staff are approachable and keep us well informed on how mother is. I know that if I say something about mum's care, staff will make the necessary changes before my next visit." Another relative told us, "My sister in law has improved so much since she came here. She seems so much happier and staff know how to care for her but still involve her in looking after herself."

People were not always engaged in activities or hobbies. We noticed that people were sat in the lounge for long periods in between meals. Some people were engaged in their own pursuits, such as conversations, knitting or reading. However, other people were either sleeping or passively watching the TV that was on. We saw three people were involved in painting during the afternoon, but there was not enough room for them to carry out this activity in comfort. We noticed that people's care plans did not evidence involvement with activities on a regular basis. This comment was also reflected in feedback from people and their relatives. One comment read, "occasional outings would be nice for them." Another relative said, "They don't seem to have many activities and staff are always too busy to spend time with people in their favourite activities." There was a programme of activities for people which included a weekly entertainer visit, singing, a quiz. People were able to participate in a weekly multi denominational religious service and meetings with visiting religious officials. One person said, "They have improved a little on activities but they don't happen every day."

A large number of people in the home were living with dementia. A member of staff said "We are aware of what could be done to make the environment more dementia friendly like painting doors different colours." The registered manager told us they were evaluating the home to look at what action they could take in making the environment more sympathetic to the needs of people living with dementia. They planned to decorate the new lounge in the extension with a clear distinction in colour between walls and the floor. They were also planning to paint all new bedroom doors different colours, which would enable people to identify their own room better. People would be involved in that choice. They said once this work was completed some of these ideas would be introduced into re-decorating the older parts of the home.

Although care records did not reflect it, people and their relatives told us they were involved in planning their care. This was evident in the information the registered manager gathered prior to people coming to live in the home. One person said, "The manager is very good at listening and will tell the staff of any changes I want to make in my care plan." A relative said, "The manager keeps us up to date on what is happening with mum's care. They always involve me in changing some aspects of the care." Staff were aware of changes to care plans and could discuss changes by talking with the registered manager.

People told us they were involved in the review of their care plans and were asked if they wished to change things within it. One person said, "I was not happy that my care plan said I needed support to eat. I call it encouragement. They changed it so that now staff talk to me rather than feed me." A relative said, "We are involved in a lot of decisions about mum's care. Any time they want to change something they will talk to us with mum and wait for mum's consent before changing the care plan." However, where we found care plans had been changed; there was no evidence to support how people and their relatives had been involved in this change.

The provider's complaints policy was available for people to use. Complaints and suggestions forms were next to the notice board in the entrance hall. There was also a letter box where people could post anonymously if they wished to. We looked in the complaints folder and saw the last complaint made had been acknowledged and responded to in a timely manner, as per the provider's policy. The registered manager discussed this complaint with us and showed how this had been resolved to the complainant's satisfaction.

Concerns were passed on to the provider through resident's meetings, questionnaires and comment slips. We saw one relative had made a request for armchair keep fit sessions. The registered manager told us this was something they were looking at providing through their entertainer and seeing if staff had experience of this. If they could not meet this need they would look at bringing someone in to do this.

Is the service well-led?

Our findings

One person told us, "[manager's name] is so approachable and treats us so well, always has time for a chat or a joke." Another person said, "[manager's name] and the team all know what they are doing and make it such a nice place to live." A relative told us, "the manager knows people very well and all of us relatives as well. There really is nothing to worry about as [manager's name] will sort out any problem we have." Another relative said, "I know that [manager's name] has mum's best interest at heart. I can talk to him about a problem and know that he will leave clear instructions for staff concerning this and that they would follow them."

The provider used an independent assessor to monitor the quality of the service provided against CQC standards. Their report was dated 28 April 2015 and made reference to the 2008 Regulations and not the 2014 Regulations. The provider did not have a copy of the new regulations but they had obtained these on the second day of our inspection. The report identified some actions for the provider to take, particularly around MCA, staffing levels and audits. The provider had not prepared a plan on what action they would take to achieving the actions identified.

The administrator carried out a monthly quality assurance audit of people's files. This identified when reviews were required of care plans and risk assessments. This system had recently been introduced but they had not set up a file containing this information. There was no audit in place of Mental Capacity assessments and best interest decisions. This would be essential for monitoring people who had fluctuating levels of capacity.

People, their relatives and professionals all told us how well run the service was. They all spoke highly of the registered manager who is also the provider. One member of staff said, "he virtually is here seven days a week and phones in when he is at home. Another member of staff said, "he does everything here, laundry, cleaning, care, whatever needs to be done, he is really hands-on." The registered manager told us they were committed to providing the best quality of care and liked to lead by their example. Staff and people told us they liked seeing the registered manager so involved. However, by spending time providing hands on care, monitoring care plans, medicine systems and supervisions of staff were not occurring as regularly as they should.

Regular health and safety checks were undertaken by the provider. These included fire alarm and equipment checks, water temperature checks, maintenance and repairs checks. Records showed these had been carried out during the week of our inspection and had been consistently completed throughout the year.

The provider told us the service philosophy was based on providing a friendly and caring service that allowed everybody to feel supported and at ease. They said, "We are committed to promoting dignity and ensuring that people's choice is respected in the care they receive." Staff confirmed this with one member of staff saying, "We are all one big family and we treat people as we would expect to be treated ourselves." There was an open culture where people, visitors and staff could speak to the manager at any time.

A comment from a mental health care professional stated, "The manager and staff at Linden House provide an excellent service for people. They are flexible in their approach to individual challenges they face. We have been able to develop effective joint care plans."

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Staff did not act in accordance with the requirements of the Mental Capacity Act 2005 for people who could not give consent. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services and others were not protected against the risks associated with not providing care and treatment in a safe way for service users. Regulation 12 (1) (2) (b)