Silverline Care Limited

Linson Court

Inspection report

Dark Lane
Batley
West Yorkshire
WF17 5RU

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

Summary of findings

Overall summary

The inspection of Linson Court took place on 4 and 6 September 2017 and was unannounced. The home had previously been inspected on 31 January and 7 February 2017 and was found to be inadequate at that time, with multiple breaches of regulations in relation to person centred care, consent, meeting nutrition and hydration needs, complaints, staffing, safe care and treatment and good governance. During this inspection, we checked and found improvements had been made in all these areas.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Linson Court is registered to provide residential and nursing care for up to 40 people in single rooms with en-suite facilities. The bedrooms are situated on two levels with a lift and stairs for people to access the first floor. Each floor has a communal lounge and dining area. There were 30 people living at the home at the time of our inspection.

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

People told us they felt safe living at Linson Court. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely, with appropriate pre-employment checks taking place. Sufficient numbers of staff were deployed to keep people safe, however, most staff felt improved quality of care could be provided if additional staff were deployed.

Risks had been assessed, such as those relating to choking, falling and moving and handling. Measures had been introduced to reduce risk and we saw moving and handling plans were in place which provided staff with information in order to safely assist people to move.

Regular safety checks took place and fire, gas and electrical systems had been tested. Plans and evacuation equipment were in place to safely evacuate people in the case of emergencies. Staff had been trained to use evacuation equipment effectively.

Since the last inspection, the deputy manager had been responsible for introducing new, improved systems

for the management of medicines. Improved systems were in place for managing, storing and administering medicines. Staff responsible for the management and administration of medicines had received training and their competency had been assessed. However, we found not all protocols for 'as required' medicines were accessible on the first day of our inspection. This had been rectified by the second day.

Although the home appeared clean and staff were observed using personal protective equipment, which reduced risks associated with infection prevention and control, a recent audit had identified actions required in order to improve infection control.

Staff had received training in relation to the Mental Capacity Act 2005 and demonstrated a good understanding of the requirements of the Act. Decision specific mental capacity assessments had been completed for people who lacked capacity to make specific decisions, as required by the Mental Capacity Act 2005.

Our observations were that, for the majority of people, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, we saw one instance where this practice could be improved and we shared our findings with the registered manager.

Care and support staff told us they felt supported and they received regular supervision. Staff received ongoing training and clinical staff received additional training to support them in their roles.

People received appropriate support in order to have their nutrition and hydration needs met. Mealtimes were a pleasant experience and people told us they enjoyed the food.

Our observations indicated staff treated people with kindness and compassion. People told us staff were caring and we observed people's privacy and dignity being respected. There was a pleasant atmosphere in the home. Diversity was embraced and the cultural and religious needs of people living at Linson Court were met.

End of life care plans had been developed where appropriate and our discussions with visitors highlighted good, effective end of life care had been provided.

Care plans contained person centred information, including people's preferences, likes and dislikes. Staff were aware of people's individual needs and preferences and we observed care was provided in line with care plans.

Audits and quality assurance systems had developed and improved since the previous inspection and these had identified areas for improvement. Continued work was required to ensure these were robust and to ensure the registered provider's action plans were met.

Staff, people and relatives spoke highly of the registered manager. The registered manager was visible in the home and knew people's needs.

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.

People told us they felt safe.

Risks to people were assessed and measures were in place to reduce risks.

Improvements had been made in the management and administration of medicines, although we found not all required medicines had relevant protocols in place on the first day of our inspection.

The home appeared clean and staff used personal protective equipment. However, a recent audit identified improvements were required to infection prevention and control practices.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was usually sought from people and the principles of the Mental Capacity Act 2005 were applied. People were usually supported to have choice and control, although on one occasion we felt a different approach by staff would have provided a person with more choice and control.

Staff had received induction and ongoing training and supervision. Clinical staff received specific relevant training.

People received support to access health care services and to meet their nutrition and hydration needs.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity was respected.

Diversity was embraced and people's cultural needs were met.

Is the service responsive?

Good

The service was responsive.

People and staff spoke highly of the activities coordinators and people told us they were able to engage in activities, if they wished to do so.

Care plans included information relating to people's likes and dislikes as well as their care needs. Care and support was provided in line with care plans.

People were encouraged to maintain contact with people who were important to them.

People and their relatives felt able to complain if the need arose.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post. People and staff told us they had confidence in the registered manager.

A recent residents' and relatives' meeting had been held, although these had not been held regularly at the time of this inspection.

Improved audits were in place and these had resulted in improvements to the quality and safety of the care and support provided. These required further development to ensure they were carried out at sufficient intervals and to ensure they continued to result in actions and improvements.

Linson Court

Detailed findings

Background to this inspection

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

The inspection took place on 4 and 6 September 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day of the inspection and one adult social care inspector on the second day of the inspection. 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 the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We used the Short Observational Framework for Inspection (SOFI) to observe one of the communal lounge areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who lived at the home and six visitors. We spoke with four care assistants, a senior carer, an activities coordinator, a cook, a team leader, the deputy manager and the registered manager.

We looked at six people's care records, four staff recruitment files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

All of the people we asked told us they felt safe. Two of the people we spoke with told us they would speak to the manager if they did have any concerns. One person told us, "Yes, I feel very safe." Another person said, "I'm very safe, they look after me very well."

Relatives also felt their family members were safe. One visitor said, "I'm sure [Name] is safe here," and another told us, "[Name] is very safe. They are very kind to [Name] and look after [them] very well."

Upon our arrival at Linson Court, we were asked to sign a record of our attendance and our identification was checked. This showed measures were in place to keep visitors, as well as people living at the home, safe because the registered manager knew who was present at the home and entry was authorised.

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. All the staff we asked confirmed they would take appropriate action if they witnessed or suspected any abuse. This helped to keep people safe because staff had knowledge of appropriate action to take if they had concerns people were at risk of abuse or harm.

The previous inspection found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risk assessments had not always been completed and, where they had been completed, they lacked meaning. We checked and found improvements during this inspection. Risks had been assessed, for example in relation to falls, choking, moving and handling and tissue viability. These were specific to each individual and to individual risks. Care records contained information regarding the measures in place to reduce risks. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

Our previous inspection found a lack of guidance and moving and handling instructions for staff. We found improvements during this inspection. We observed staff assisted some people to move using equipment. This was done in a safe, supportive and reassuring manner. Moving and handling plans contained information specific to the person's individual needs and included information such as the specific equipment required and precise method of application. We saw one moving and handling plan stated, 'Do not hoist [Name] until you have been assessed by [deputy manager] and are confident with the procedure.' This meant staff received appropriate guidance to assist people to move in a safe way. However, we did observe staff assist a person who found it very difficult to move. We felt staff and the person would benefit from having their moving and handling needs reassessed, in consideration as to whether moving equipment would be required. When we raised this with the registered manager, they confirmed to us they were aware this person had deteriorated and were already looking into this.

Where people required specific equipment, such as pressure relieving cushions, we saw staff ensured these were in use and we saw people were seated on their cushions. When people transferred from chairs to wheelchairs or wheelchairs to chairs, staff were seen moving cushions which helped to ensure appropriate

care was provided to reduce the risk of skin damage. Some people were assisted to reposition regularly because their skin was at risk of pressure damage. We saw one person had very specific needs and had a particular sleep system in place which had been recommended by an occupational therapist. Pictures were available for staff to follow in order to ensure the person was correctly positioned. This helped to ensure safe, appropriate care was provided.

People were encouraged to stay healthy. One visitor told us, "[Name] refuses to eat and wash. They [staff] are very patient. If [Name] refuses to wash, they don't just leave it at that. They come back a few times and keep asking. Same if [Name] won't eat." This showed staff took steps to help people maintain their health.

We looked at how premises were maintained and kept safe. Fire evacuation notices were displayed throughout the home and we saw fire evacuation equipment had been recently serviced. Staff told us they had attended fire safety training and had been given training on how to safely use fire evacuation equipment. A member of staff explained to us the actions they would take in the event of an emergency.

There was a bag accessible to staff which contained items that would be useful in an emergency such as a high visibility vest, a torch, emergency contact details and personal emergency evacuation plans which included photographs of people. This showed measures were in place to help keep people safe in an emergency.

At our previous inspection two downstairs bathrooms were out of action and the manager was unable to confirm what actions had been taken to resolve the maintenance issues. During this inspection, we found the bathrooms were in working order. A maintenance book was in use and this recorded any repairs or maintenance issues. Records showed issues were addressed and repairs were undertaken, where necessary, through this system.

Regular routine maintenance checks took place, for example in relation to the safety of windows, water and room temperatures, fire doors, bedrails and external areas to the home. Up to date certificates for gas and electrical safety were in place. Weighing scales were serviced and calibrated and lifting equipment was inspected and tested. This helped to ensure premises and equipment were safe and fit for purpose.

We looked at records of accidents and incidents. We saw these were logged and records showed appropriate actions had been taken such as dressing wounds, increasing observations and making referrals to other healthcare professionals. Monthly analysis took place to enable trends to be identified to assist the registered provider to make improvements.

We considered the staffing levels at the home. A dependency tool was used, which considered the needs of each person in order to generate a score, depending on the person's risk and needs. This helped the registered manager to determine staffing levels, depending on the level of need. People's dependency levels were evaluated and updated monthly.

All of the staff we asked told us there were enough staff to keep people safe. However, most staff told us they felt they did not have time to sit and hold conversations with people and spend as much time with people as they would like. We noted there had previously been a complaint in relation to staffing levels. The registered manager had taken action and replied to the complainant, who then confirmed they were satisfied with the response and the actions taken by the registered manager. A relative we asked told us they had no concerns with staffing levels.

During the morning of the first day of our inspection, we spent time in a communal lounge. There were five

people sitting in the lounge. We noted staff attended to the lounge area regularly and could be heard asking whether people were okay and whether they would like a fresh drink or assistance. This confirmed to us the staffing levels were appropriate to meet the needs of people in these areas.

We inspected four staff recruitment files and found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups of people.

The previous inspection found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely. We looked at how medicines were managed and administered and found improvements since the last inspection. The staff member administered medicines in a kindly manner. At the last inspection we found staff did not always ensure medicines had been swallowed. During this inspection we observed the staff member stayed with each person until they had taken their medicine and people were not rushed.

Each person's medicines administration record (MAR) contained a photograph which helped reduce the risk of medicines being given to the wrong person. Details for wound care, a body map and plan for skin care were in place. Body maps help to ensure staff know where to apply creams.

Some people were prescribed PRN, or 'as required,' medicines. Staff asked people whether they required their PRN medicines. There were some PRN protocols in place to guide staff when these may be needed. PRN protocols help to ensure these medicines are administered appropriately and at safe intervals. However, some people who took PRN medicines did not have a protocol in place. This had been a concern at the last inspection and the registered provider had not taken appropriate action to address this. On the second day of our inspection, the deputy manager confirmed and showed us these protocols were in place. We were told these protocols had been devised but were not in place in the MAR. Therefore they had not been accessible to staff administering medicines. This was rectified during our inspection.

The previous inspection found some people were given medicines covertly, without appropriate consultation to ensure this was safe. We checked at this inspection and found some medicines were crushed and discussions had taken place accordingly with the prescriber, GP and pharmacist.

Our previous inspection found a person was prescribed a specific medicine which required the person's pulse to be checked prior to administration and records had shown this had not always happened. We checked during this inspection and found a person was taking this medicine. We checked the person's records, which showed their pulse had been checked each time prior to administration. This meant the guidelines were now being followed and risks to the person were reduced as a result.

Some people were prescribed medicine which needed to be administered 30 minutes before food. The MARs did not indicate whether this was being followed. However, the staff member administering medicines was aware of this requirement and explained to us how they ensured people received their medicines 30 minutes before food.

At the last inspection we found all staff had access to the locked treatment room containing large quantities of medicines. Action had been taken to address this and keys for the treatment room were now kept by only those staff with responsibility for administering medicines. Medicines were well organised, labelled and dated in a secure storage area.

At the previous inspection we found some thickening agent (which is added to drinks to minimise the risk of choking) was stored insecurely in people's rooms. This substance is potentially hazardous if swallowed undiluted. We found, during this inspection, although this substance had been removed from people's rooms and had been stored in locked cupboard, we saw the key remained in the lock. We checked the cupboard door on the second day of the inspection and found this to be unlocked. This meant the substance was insecurely stored. We shared this concern with the registered manager who agreed to address this.

Items were clearly labelled with expiry dates and dates of dispensing and opening clearly recorded. Room and fridge storage temperatures were regularly checked to ensure medicines were stored at the correct temperature.

A monitored dosage system was in use for most medicines with some other medicines being supplied in boxes. A count record sheet was in place and this meant a running total was held for these medicines.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and logged in the register as required. This showed controlled drugs were managed appropriately. We checked a random sample and found the amount of medicine remaining was correct, according to the register.

Since the concerns raised at the last inspection, the deputy manager had taken responsibility for improving the management of medicines and improvements were clearly evident. At the time of this inspection, the deputy manager was responsible for ordering, booking in, administering, returning and sometimes auditing medicines. This meant there was an increased risk of medicines errors because the same member of staff was managing every aspect of medicines management. The deputy manager and registered manager explained to us the deputy manager had needed to take initial control of all aspects of medicines in order to improve the systems and the intention was to share responsibility and new systems with other qualified staff, in order to reduce this risk. The registered manager shared with us a document outlining the system in place for the management of medicines. This helped to ensure other staff, who had been trained to administer medicines, were aware of processes, in case of the absence of the deputy manager. This meant, although there were increased risks because the same staff member was responsible for all aspects of medicines management, action was being taken to address this and reduce risk.

We found the home appeared clean. Staff had access to personal protective equipment and we saw staff making use of this where appropriate. Information relating to effective hand-washing techniques was displayed in appropriate areas. This helped to remind staff of good infection control practice. A relative told us the standards of cleanliness raised no concerns for them. The local authority had recently completed an infection prevention and control audit and this had resulted in an action plan with some required actions in order to make improvements to infection control practice.

Requires Improvement

Is the service effective?

Our findings

We observed staff to be effective in their roles. People told us they were happy with staff and they enjoyed their meals. One person commented, "They try very hard to give us variety. Three meals a day, seven days a week. It's hard to change things every day. It's usually very good." Another person told us, "You get a choice."

The previous inspection found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to concerns regarding competency assessments of staff administering medicines and lack of clinical training and leadership. We found, since the last inspection, staff competency had been assessed in relation to medicines. This consisted of a self-assessment and an assessment by a further trained person.

The staff we asked told us they felt they had received adequate induction into their roles, which included shadowing more experienced staff members. We looked at an induction booklet for a nurse, which included information specific to nursing staff, including the management of medicines, care file documentation, actions to take in emergencies and infection prevention and control.

We looked at the individual training record for a recently appointed nurse. Records showed the nurse had undertaken training in areas such as safeguarding, fire safety, health and safety, moving and handling and equality and diversity as well as training in relation to clinical areas of care, for example, tissue viability, urinary catheterisation, palliative care, anaphylaxis management and percutaneous endoscopic gastrostomy (PEG) feeding. We noted, where a nurse had indicated in an assessment they felt they were not confident in a particular area of care, it was arranged for the nurse to attend a training course to refresh their knowledge in this type of care provision. This showed clinical staff received additional training when required to help ensure they had the skills to perform in their role.

Staff told us they felt supported and they received appropriate training. A member of care staff told us, "They [the registered provider] always want us to do more training. They want people to move forward." However, one member of staff did share with us they felt that, as much of the training was online, this was not always effective. Recent syringe driver training had taken place. A syringe driver is a small portable machine that is able to provide medicines constantly (usually over 24 hours) via a small needle under the skin. On the second day of our inspection a nurse told us they had completed this training and told us, "It was brilliant."

No staff were currently working towards the Care Certificate because there were no staff new to care. However, the registered manager was aware of the principles of the Care Certificate and advised they used this as a benchmark for induction. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

The registered manager told us one to one supervision took place every two months and the records we reviewed supported this for care and support staff. The staff we asked told us they had recently received

formal supervision. However, although the registered manager received regular supervision, we noted the deputy manager had received only one formal supervision, as well as an appraisal, since commencing employment in March 2017. This meant, although formal supervision had improved since the last inspection, continued improvements were required to ensure this applied to all staff, including the deputy manager. Following the inspection, the registered provider contacted us to advise that the deputy manager had received additional support and guidance following their induction, as well as two formal supervisions and an appraisal. There was a plan in place for staff supervisions to take place throughout the rest of the year, including the deputy manager. We looked at a record of one to one supervision for a clinical member of staff. This had included appropriate discussions in relation to a review of performance, personal development, health and included comments from the supervisee and supervisor.

The previous inspection found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because consent was not always sought and staff did not always act within the requirements of the Mental Capacity Act 2005 (MCA). The 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 so they can 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The staff we asked and the registered manager understood the requirements of the MCA and related DoLS. Where people lacked capacity to consent to their care and treatment and where they were being deprived of their liberty, appropriate authorisations had been sought. We noted one person's DoLS authorisation had a condition attached. The registered manager was aware of this and was taking action, as required by the condition. DoLS applications were well managed and the registered manager was aware who had authorisations in place and when they required renewal.

In one of the care plans we reviewed, the person lacked capacity to make multiple decisions, for example those in relation to the administration of medicines and use of bed rails. Reference was made to this throughout the care plan and it was evident the home had assessed the person's capacity and held discussions with relevant family members in order to ensure they were acting in the person's best interests, in relation to each decision.

The previous inspection found, where a person was given covert medicines (that is, without the person knowing), this had been done so without appropriate safeguards in place and contrary to the MCA. We found during this inspection, a person's capacity to make decisions in relation to their medicines had been assessed and the decision was taken in their best interests, in consultation with relevant people and in line with the principles of the MCA.

Care plans had been re-written and we saw some consent forms were signed and others were not. The registered manager was aware of the need to ensure only those people with appropriate Lasting Power of Attorney were able to consent on behalf of another person. Their work in this area was continuing.

We observed many interactions throughout the inspection which demonstrated consent was usually sought

from people before providing care or intervention. For example, staff were heard saying, "Would you like. . . ?" and, "Can I fasten your . . .?" We overhead a member of staff, who was assisting a person to eat breakfast in their room, say, "Morning [Name]. I've brought you some breakfast. Is it alright if I sit you up?" This showed the staff member sought consent prior to assisting the person. The staff member then confirmed with the person their choice of breakfast was correct.

However, this was not consistent and, on one occasion, we saw a person was assisted to move by staff into the dining room, without the person giving consent. The person was indicating they wished to stay on the sofa in the lounge but staff moved the person to the dining room to eat. We shared our observation with the deputy manager, who advised the person needed encouragement and assistance to eat; otherwise they were at risk of malnutrition. The person's care plan indicated this to be the case. However, we felt other options could have been considered such as asking the person if they would prefer to take their meal in the lounge, as opposed to the dining room. We shared our concern with the registered manager, who agreed to address this further with staff.

The previous inspection found a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate action was not always taken in order to ensure people's nutrition and hydration needs were met. During this inspection, we found people were weighed regularly and, where concerns or changes to people's needs were identified, contact was made with other relevant health care professionals. We heard the deputy manager sharing information with a GP in relation to different needs, such as a person's medicines and another person's hydration needs.

We spoke with the cook, who was knowledgeable about people's dietary needs. The cook explained how they fortified people's meals if they were at risk of malnutrition. Diet notification forms had been completed for each person living at the home and these were available to kitchen staff. These included details regarding individual requirements such as the required consistency of food, allergies, likes and dislikes and choking risks. We saw examples of people being offered food which correlated with their 'likes' on their diet notification form.

Staff spoke to each person and offered choices of what they could have for dinner and tea. Two choices were offered each mealtime. Explanation was given about each option to help the person to choose. However, we did not see staff use any other aids to help people decide what to eat, such as pictures or presenting plates to people to help them choose.

Staff were aware of people's individual needs. For example, a member of staff was aware that one person would drink more if they used a straw, rather than a cup. We saw a staff member brought the person a straw and sat with the person to assist them to drink more, to good effect. This helped to ensure the person was hydrated.

People's food and fluid intake was recorded by care staff on an electronic system. This enabled the registered manager to monitor intake. The registered manager generated a report from the system daily and highlighted any concerns to clinical staff, in order for appropriate action to be taken. We saw records, such as food and fluid were completed and up to date.

Food was prepared and managed in line with specific requirements. For example, the Universal Halal Agency had provided certification of Halal accreditation. In June 2017, the home had been awarded a food hygiene rating score of five, which equates to 'Very good.'

We looked at the design and layout of the building. Pictures were displayed in the reception area of people

participating in various activities. Historical pictures of the local area were displayed on corridor walls. There was a clean, well maintained fish tank in the lounge area.

There was programme of improvement and refurbishment underway. The registered manager showed us samples of new décor for bedrooms. The registered manager told us people were asked for their input and asked which designs they would prefer.

People had access to healthcare. We heard a person say they wanted to see their doctor. A member of staff listened to the person and gave the person assurance about what they would do. During our inspection we heard a member of staff tell a person they had made a referral to audiology because the person was having problems with their hearing aids.

Records showed staff at the home had contacted different health care professionals when appropriate such as occupational therapists, doctors, speech and language therapists and opticians. Some recent on-site eye examinations had taken place. This showed people received support in order to meet their health care needs.

During our inspection, a concern was raised that there was an expectation families would source primary health care such as a dentist, if a person required registering. The registered manager explained to us they would not expect family to do this and there may have been one occasion, when the registered manager was absent from work, that a family sourced dental care for their loved one. The registered manager was in the process of investigating this and assured us they would share the outcome with us.

Good

Is the service caring?

Our findings

People and relatives told us staff were caring. One person said to us, "The care? If I said it was perfect that would be too much, but it's near to perfect." Other comments from people included, "The staff come in and talk to me and we have a right laugh," and, "They look after me very well. They go out of their way to help me."

A relative told us the care at Linson Court was, "Good on the whole." We were told staff attitude was welcoming and friendly. Another relative told us, "[Name] can be very awkward but they [staff] always treat [name] with respect." A further visitor said, "Staff are very helpful and polite. They always say hello when I visit," and another visitor told us, "We are very happy with the care. We always have been."

Staff enjoyed working at the home and were motivated to provide good quality care. A carer told us, "I'd be happy for a member of my family to live here. I think it's a good place. Staff are friendly. There's a good atmosphere."

Staff were very polite, courteous and encouraged people, for example to drink plenty of fluid. During mealtime, we observed a member of staff sitting with a person offering one to one support to eat their porridge. There was lots of chatter and laughter in the dining room. One person was heard talking to another person, telling them how much they enjoyed going to church. A member of staff commented about how well a person could sing and all four people then burst into song. There was a pleasant atmosphere.

People were assisted whilst being given choices. For example, a member of staff was observed assisting a person to turn on their television in their room. The staff member asked the person which channel they wanted to watch. When staff assisted people to move we saw people were asked questions such as, "Would you like a cushion for your back?" and, "Would you like your feet up?"

We observed a person being assisted to move with the use of a hoist. Staff provided lots of reassurance and smiles. We heard staff say to the person, "We're going up, are you okay?" and, "Won't be long, you'll soon be nice and comfy."

We observed two staff assisting another person to move. We noted the person's trouser leg began to ride up as they were being assisted. Staff were observant of this and discreetly ensured the person's dignity was not compromised by adjusting the person's trousers in a caring manner.

Care staff demonstrated a good understanding of how to respect people's privacy and dignity. One staff member said, in relation to providing personal care and support, "It depends on the individual. I close curtains and make sure doors are closed. Always knock. You need to get to know people. They're all individuals."

Care plans indicated people should be encouraged to maintain their independence. For example, one care record we reviewed stated, '[Name] has capacity to make own choices regarding what to wear. [Name] to be

encouraged as much as possible to maintain their independence. Staff to offer choices.' This showed choice and independence were considered during the care planning process.

People's cultural and religious needs were given consideration and the registered manager and staff strived to meet people's individual needs. Some people were supported to attend their place of worship in the local community. Additionally, services were held at the home. One person had a radio link to their local place of worship and this meant they could listen in to prayers which were being held. Some people required a specific diet, in line with their religious need and this was provided. A relative told us, "We [referring to religion] have to be very clean. They [staff] allow me and the family to come in and wash [name] whenever we need to. They are very helpful in facilitating this." This showed people's religious needs were respected and families were able to be involved in this important practice.

Our last inspection found end of life care plans had not been considered. We checked during this inspection and found improvements had been made. Care plans included end of life wishes where appropriate. In some plans these included specific information in relation to the person's religious and cultural needs. Where a person lacked capacity to contribute towards their end of life care plan, records showed the registered manager had liaised with family to ensure appropriate needs were recorded.

We learned of one person where it was important for the person, who was at the end of their life, to have their family present. Therefore the registered provider accommodated family members in a room near to their loved one. This meant the person and their family could be together, as they wished, and family were provided privacy. A family member told us, "[Name] could not have been better looked after. The staff were lovely."

Good

Is the service responsive?

Our findings

The previous inspection found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because not everyone had a care plan. We checked and found improvements during this inspection. Every care plan had been re-written since the last inspection and everyone living at the home had a care plan, including the person who was most recently admitted to the home.

Care plans included an assessment of need, details of care interventions and monthly evaluations in relation to needs such as mobility, wound care, communication, oral health care, personal hygiene and continence. Included in the care records were details of people's preferences in relation to whether they wished to have a key to their room and whether they preferred to have their bedroom doors open or closed. Records included information relating to people's likes, dislikes and life history. This information enabled staff to provide personalised care and support. People's rooms were personalised and contained photographs and other items and mementos of sentimental value.

The registered provider was moving towards an electronic care record system. At the time of this inspection, care plans were in a written format and were well organised in a file. These provided staff with the information they required to provide effective care and support to people. The records of care provided, activities undertaken, food and fluid intake, weights and repositioning records were inputted by staff onto a system by handheld electronic devices. The registered manager was then able to use the information to download reports, using different parameters, to analyse information. This meant the registered manager was able to have an oversight of people's care.

One person's care plan indicated they were able to communicate by using particular facial expressions. We asked a member of staff how this person communicated. The staff member was able to describe the relevant techniques and facial expressions the person used. This showed staff were aware of the specific communication needs of people. The home employed some bi-lingual staff and this meant they were able to communicate with people whose first language was not English.
People were encouraged to join in activities and occupation. One person told us, "I went to the canal and boat show," and another person said, "I went shopping to Dewsbury market." There were two dedicated activities staff employed at the home. Activities included board games, floor games, arts and crafts, group discussions and church services. Additionally, some activities took place in the community. For example, a recent garden party had taken place and a recent trip to a canal festival. Staff spoke positively about the activities coordinators. Comments included, "There's a good range of activities," and, "Yes, there's definitely enough for people to do," and, "They're really good at getting to know people and what they like. Things are a lot better than when you were here last [meaning the last CQC inspection.]"

We spoke with an activities coordinator and they were clearly keen to engage people in activities and meaningful occupation. They were able to provide details of programs they were developing to introduce more person centred activities and work in this area was ongoing.

Many people chose to stay in their rooms. They confirmed to us this was their choice. One person told us,

"They come and say we have this to do and that to do but I don't want to go." Another person said, "There is a lady that comes and brings lots of things, to see if I like them, but I'm too old." The activities coordinator told us of work they were doing in order to try and engage this person in some occupation.

When staff assisted people into the lounge areas, people were asked where they would like to sit. Other choices were offered such as choice of meals. One person told us they liked to have a particular type of sauce with their meal, and this had been accommodated. This showed people were able to retain a level of control by making their own choices. However, as discussed earlier in this report, we saw one person was assisted without the person providing consent.

The previous inspection found a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because complaints were not always recorded and acted upon. During this inspection we checked how complaints were managed and found improvements.

The complaints procedure was displayed in the home. We found, where complaints had been made, action was evident. We saw the registered manager responded to the complainant and one complainant replied by stating they had, 'Considerable confidence in [the registered manager] and have noticed the positive response she receives from her team.'

A complaint was made during our inspection regarding a person's access to a dentist. The registered manager opened the complaints procedure and we asked the registered manager to keep us informed of the outcome of this.

A relative told us, "I don't think I'd need to but I would speak to the manager if I had any concerns."

Staff shared information relating to people's needs, for example through daily handover meetings. We looked at handover records which had improved since the last inspection and showed appropriate information was shared between staff to enable continuity of care when staff changed. These included information such as diet, allergies, moving and handling needs and other comments such as medical condition. In addition, a 'flash meetings' book was in use which recorded daily any relevant information which could be shared with staff.

Requires Improvement

Is the service well-led?

Our findings

People and staff had confidence in the registered manager. One person told us, "I see the manager. She walks around and speaks to me. I'd tell her if I had any concerns."

A relative told us they had noticed much improved care recently. They told us they had a good relationship with staff and the deputy manager and registered manager were visible throughout the home. Another relative told us they had noticed improvements in the quality of care and cleanliness. They told us staff were friendly and they could visit any time. This relative told us they felt informed about their family member's care and developments at the home.

At the last inspection, the home did not have a registered manager in post, although there was a newly appointed manager. The manager was now registered with the Care Quality Commission (CQC).

The deputy manager and registered manager explained to us they had worked, "Incredibly hard" to improve the quality and safety of care provided at Linson Court. This was evident through records, our observations and the comments we received from staff and relatives of people living at the home. The deputy manager and registered manager both told us they had, "High standards." Since the previous inspection, the registered manager's office had been moved from the ground floor to the first floor. This made the registered manager more accessible to people and staff.

The registered manager told us the Chief Operating Officer for the registered provider visited the home at least weekly and the registered manager had one to one supervision fortnightly. The registered manager told us they felt supported in their role.

All the staff we asked told us they liked working at Linson Court and they felt supported by the deputy manager or registered manager. We were also told measures were in place for the home to run well in the case of their absence. A member of staff told us, "We can always contact the area manager. They're helpful and approachable and they know everyone here."

A member of staff said, "I'm definitely able to talk to [the registered manager]. If I had any questions or ideas, she's not the sort to dismiss you." Another member of staff said, "I think [the registered manager]'s doing really well. I'd be able to go to her with any concerns. There are definitely improvements."

We were told by a member of staff, "Staff morale has improved. We're improving. We have a good manager, a good deputy and good staff." Another member of staff told us, in relation to the managers of the home, "They're very open. Any concerns are managed well. I feel we're improving. I like what [the registered manager]'s trying to do. I find her very open."

All the carers we asked told us they all had a good relationship with each other and the team worked well together.

Care staff told us staff meetings were held regularly. We looked at records of the most recent staff meeting which showed items such as care plans, catering, laundry, maintenance and confidential information was discussed. Staff had been kept informed of actions the registered provider had taken since the last inspection. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Monthly meetings were also held with senior carers and nurses. Records showed people's needs were discussed and any other issues, such as medicines and recording. Records showed a meeting which took place during July 2017 indicated there would be twice weekly audits of medicines. However, the deputy manager and registered manager were not able to show records of these medication audits. Both told us regular checks were made to ensure medicines were being recorded correctly but these were not recorded. This meant we were not able to verify the twice weekly audits took place.

The registered manager told us they kept abreast of regulations and best practice by attending local authority best practice events and by subscribing to recognised journals and CQC newsletters.

Community links were evident and local schoolchildren attended the home regularly. Links had been made with local places of worship. We saw a poster was displayed, advertising an upcoming coffee morning to raise funds for a well known national charity.

The registered provider's vision was clearly displayed in the home. The vision was, 'To become the leading care home in all our local communities.' The registered provider's values were, 'Putting people first. Act with integrity. Share ways to achieve excellence.'

The previous inspection ratings were displayed in the home and on the website. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

Feedback cards were displayed in the reception area, enabling families and visitors to review the home. Recent comments submitted included, 'I am happy with [Name] in Linson Court and wouldn't want [them] to go somewhere else.'

The registered manager and Chief Operating Officer told us quality questionnaires were due to be sent to people and relatives in order to gather their views of the service, but these had not yet been sent. A residents' and relatives' meeting had been held during the month prior to this inspection. Records showed items were discussed such as developments at the home, introduction to new staff, activities and updates on actions since the last CQC inspection and feedback was invited from people and relatives. This showed the registered manager was engaging with people and their relatives.

The previous inspection found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was little assessment and monitoring of the quality of the provision and there was a lack of clinical leadership. We found improvements at this inspection. For example, all staff administering medicines had their competency assessed and clinical staff had attended further clinical training and received one to one supervision and appraisal. During this inspection, clinical staff demonstrated good knowledge of people's needs.

Audits of care plans took place using an electronic tool. This identified areas where improvement was required such as whether care plans were up to date and included relevant information, for example risk assessments, daily progress records, photographs and plans for each area of care. The registered provider

had submitted an action plan indicating a minimum of ten care plans would be audited each month. Records showed an average of eight care plans had been audited each month during the three months prior to this inspection. This meant, although plans were being regularly audited, this required further work to ensure the registered provider's action plans were being met. The registered manager told us their intention was to increase the number of care plans being audited to five each week and this would be done in line with room numbers, to ensure all care plans were audited.

Records showed some audits were effective. For example, we saw an audit of a care plan identified a person's sleeping care plan required evaluation and the plan lacked mental capacity and deprivation of liberty safeguarding information. We checked the care plan and saw this had been actioned. This showed the audit had resulted in improvement.

The registered provider also had systems in place to undertake other audits such as those relating to health and safety, the environment, mattresses and medicines. We saw these were completed and actions taken, for example mattresses being cleaned or replaced as a result. Medicines audits had been completed monthly by either the deputy manager, registered manager or Chief Operating Officer.

We noted, for some of the audits we reviewed, it was difficult to determine whether resulting actions had been completed. The Chief Operating Officer told us actions from audits were collated and there had been a system in place to ensure actions were followed up. However, this system had become too cumbersome and difficult to manage so they were working on a new process to ensure audits continued to result in actions, in order to continue to drive improvements at the home. This meant, although there were improvements since the last inspection and audits were taking place, these needed continued development in order to be fully effective.

Thank you cards were displayed in the reception area of the home. Many positive comments had been received by relatives, indicating staff were caring and people's end of life, cultural and religious needs were met.