Sussex Partnership NHS Foundation Trust

Lindridge

Inspection report

Laburnham Avenue
Hove
East Sussex
BN3 7JW

Tel: 01273746611

Date of inspection visit:
30 March 2016

Date of publication:
17 June 2016

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?	**Good**

Summary of findings

Overall summary

Lindridge is a large residential care home providing care and support for up to 75 people. Since the last inspection in May 2014 the home has been through a period of considerable growth and change with an increase in the number of people that can be accommodated from 25 previously to 75. This has involved the redesign, extension and refurbishment of the building to accommodate a number of short term beds for people leaving hospital, as well as a specialist dementia unit and a unit for people with behaviour that can challenge. On the day of the inspection the specialist unit for people who have behaviour that can challenge was not yet open and there were 48 people living at Lindridge.

The home has 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.

Not all medication practices ensured that medicines were managed safely. Medicines that required refrigeration were not always stored within the required temperature range and there was a recording omission in the MAR chart for one person. Pain assessment charts held for each person stated the pain relieving medicines they had been prescribed. Some entries on these did not state a minimal interval between doses, or a maximum daily dose. These instructions are needed to ensure the safe administration of medicines.

We checked whether staff were working within the principles of the MCA and whether conditions or authorisations to deprive a person of their liberty were being met. None of the staff members that we spoke with could tell us about the implications of DoLS for the people they were supporting. We identified this as an area of practice that needs to improve. Staff were able to demonstrate a good understanding of the MCA including the nature and types of consents, people's right to take risks and the necessity to act in people's best interests when required. However they were not consistent in their approach to undertaking Best Interest decisions.

People were not always consistently supported and monitored where nutritional risks had been identified. One person had been assessed by a Speech and Language Therapist (SALT) due to difficulties with swallowing however staff were not aware of the identified risks for this person or the SALT guidance regarding positioning, monitoring and advice stating that the person should be supervised when eating. This meant that identified risks associated with eating and drinking were not being appropriately managed.

People told us they felt safe living at Lindridge, one person said, "I feel secure here, the staff know how to care for me and the other people here." Risks to individuals were identified and managed including environmental risks and risks of infection. Staff were knowledgeable about the correct procedures to follow should they suspect abuse and there were robust recruitment procedures in place to ensure that staff were suitable and safe to work in the care sector. People told us that there were enough staff on duty to care for

them, one person said "Staff are still busy but they make time, I have never felt rushed by anyone." Throughout the inspection we observed that staff were spending time with people, providing care but also just chatting and keeping people company. Staff rotas showed that staffing levels were maintained and we saw evidence that recruitment to vacant posts was in progress.

People told us that they felt well cared for, that staff were kind and their views were valued, saying "They do treat me with respect and maintain my dignity, they shut the door and pull the curtains before attending to me." Throughout the inspection we saw positive interactions between staff and people with many examples of staff demonstrating that they knew people well and treated them with kindness and compassion. People were offered choices around food and told us that they enjoyed their meals, we saw that meal times were a social occasion and that staff were supportive and attentive to people both in the dining areas and those choosing to eat in their own rooms.

People were supported to maintain their health and to have access to healthcare services. People told us that staff were proactive in seeking help and advice from health care professionals when they needed to and records confirmed this. One person said, "I think it is excellent here, the best care I have had in my life." People and relatives told us that there was a focus on individual needs and that they were included in the review process. Care records were well personalised and detailed and we saw that there were effective systems in place to support staff communication regarding any changes in people's needs. People were supported to follow their interests and there was a varied activity programme available arranged by two activities co-ordinators.

Staff told us they were well supported and that opportunities for training and development were good. There was a clear management structure and staff told us that the registered manager was approachable and accessible. Morale was good and staff told us that they enjoyed their work, comments included "I love it here. This is the best job in the world," and "I've worked here a long time, I wouldn't stay if I didn't like it, it's a happy home."

The adaptation, design and decoration of the home took into account the needs of the people living there. The home had been designed to accommodate people who used wheelchairs and a lift provided access to the upper and lower floors. People told us that they were able to access communal areas with ease, one person who used an electronic wheelchair told us "I can get around easily, I go out in the garden too, in the front they have raised beds which is good for people in wheelchairs." We saw that consideration had been given to the needs of people who were living with dementia for example, a wall- mounted screen had been adapted to give the appearance of a television from the 1950's and the images it displayed were also of that era, staff said this was designed to stimulate pleasant memories for people.

People told us that they would feel comfortable in raising any issues or complaints with staff or with the registered manager. There was a system in place for managing complaints and that the registered manager was proactive in seeking feedback from people and their relatives.

There were effective monitoring systems in place to check the quality of the service and the registered manager used this information to drive improvements in the service. Staff had developed good links within the local community and with health and social care services. Staff described a fair and open culture where they were able to raise issues and be supported. People, relatives and staff spoke highly of the registered manager and senior staff and told us that the home was well led, their comments included "The home is run pretty well" and "This is a well- managed home."

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can

see what action we told the provider to take at the back of the full version of the report,

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all medication practices ensured that medicines were managed safely

Risks to people were identified and managed. People were protected by the prevention and control of infection and environmental risks were managed appropriately.

Staff demonstrated a good understanding of the procedures for safeguarding people.

There were sufficient numbers of staff to keep people safe and meet their needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff demonstrated a good understanding of the principles of the MCA but were not consistent in their approach to undertaking Best Interest Decisions and had little awareness about the implications of DoLS for people they were supporting.

People were not consistently supported and monitored where nutritional risks had been identified.

People were supported by staff who had received appropriate induction , training and supervision.

People were supported to maintain their health and well-being and staff were proactive in seeking access to health care professionals when required.

The design, adaptation and decoration of the service supported people's individual needs.

Is the service caring?

Good

Staff were caring. People and their relatives spoke highly of the kind and caring nature of the staff.

Staff knew people well, understood their needs and had developed positive relationships with them.

People were involved in planning their care and felt that their views were listened to and respected.

People were supported to maintain their dignity and privacy.

Is the service responsive?

Good

Staff were responsive to people's needs.

Care records were detailed, well personalised and regular reviews were undertaken.

People were supported to follow their interests and their preferences and wishes were identified and respected.

There was an effective complaints system in place and people and their relatives were encouraged to provide feedback on the care provided.

Is the service well-led?

Good

The service was well-led.

People and staff spoke highly of the registered manager saying that she was approachable and provided good leadership

Staff were well motivated and understood their responsibilities.

There were effective quality monitoring systems in place and these were used to drive improvements.

Lindridge

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 comprehensive inspection took place on 30 March 2016 and was unannounced. The inspection was undertaken by two inspectors, a pharmacist specialist adviser, a residential care specialist adviser, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service and in this case had expertise in residential nursing and dementia care services.

Prior to the inspection the provider had completed 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 any improvements they plan to make. Other information that we looked at prior to the inspection included previous inspection reports, safeguarding concerns that had been raised and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also spoke to the local authority and to the Clinical Commission Group. This enabled us to identify areas to be looked at during the comprehensive inspection.

During the inspection we spoke in detail with 17 people, seven relatives or visitors, and 15 staff members. We looked at areas of the building including people's bedrooms, communal areas, the kitchen and gardens. We spent time sitting and talking with people, visitors and staff and observed the delivery of care, the lunchtime medicines being administered and other activities in the home. We looked at a range of care records, staff records, medication administration records (MAR), minutes of meetings, incident and accident reports, policies, audits and quality assurance documents.

Lindridge was last inspected on 16 May 2014 and no areas of concern were noted.

Requires Improvement

Is the service safe?

Our findings

People spoke highly of the support they received at Lindridge and told us that they felt safe. One person said "The care is fantastic, the carers are well trained and that makes me feel safe," another person said, "I feel secure here, the staff know how to care for me and the other people here," and a third person said, "I don't have any worries here, security is good, the staff are good and the manager is good." Relatives also told us that they were confident that people were safe and well cared for. One relative said "I am here most days, I have never seen anything that would worry or concern me, the staff know what they are doing." Another visitor said "We've never seen or heard anything bad here and we've been coming over a year, I would speak to the manager straight away if I saw anything untoward." Despite this positive feedback we found some areas of practice that required improvement.

We found that medicines were not always managed safely. Medicines were kept safely and stored securely. We viewed records which showed staff had received training on medicines and checks had been undertaken to ensure they were able to administer medicines safely. We were told one member of staff was trained to administer medicines using a syringe driver (a system which allows medicine to be administered by slow release over a period of 24 hours). A competency assessment had been undertaken for this. Arrangements for ordering and receiving people's medicines from both the GP and pharmacy were suitable. There were also arrangements to obtain medicines that might be needed urgently in addition to people's usual requirements (such as antibiotics). There were suitable processes in place for the management of waste medicines. Observations showed three people being supported to take their medicine. Staff supported people in a caring and respectful way, they stayed with the person to ensure that they had swallowed the medicines and drinks safely. There were also processes in place to allow people to administer their own medicines, where this was appropriate. Suitable processes had been followed and correct documentation was in place for people requiring covert administration of medicines. We saw examples of positive instructions for medicines prescribed for behaviour that could be challenging which clearly advocated use of behavioural measures, tailored to each person, before the use of the prescribed medicine.

Records showed that medicines requiring refrigeration were not always stored between the recommended 2°C and 8°C. Guidance from the Royal Pharmaceutical Society of Great Britain (RPSGB) states that 'Medicines need to be stored so that the products are not damaged by heat or dampness' this is because changes in temperature and moisture can affect the efficacy of the medicine. Some medicines administration records (MARs) contained handwritten entries, these had not been double checked to reduce the risk of transcription errors. The Nursing and Midwifery Council (NMC) Standards for Medicines Management state that when MAR charts are handwritten that they must be checked by another competent health professional. There was an omission in a MAR chart for a medicine that should not be stopped abruptly. This meant that it was not possible to determine accurately whether the person had received their medicine. This was brought to the attention of the registered manager who undertook an investigation and has subsequently informed us that this was an error in recording and steps have been taken to ensure this error is not repeated. Pain assessment charts held for each person stated the pain relieving medicines that they had been prescribed. Some entries on these did not state a minimal interval between doses, or a maximum daily dose. These instructions are needed to ensure the safe administration of medicines. Due to

the above concerns in relation to the proper and safe management of medicines we found this to be a breach of Regulation 12 (1) and (2), (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

Staff had undertaken safeguarding training within the last year and demonstrated a good understanding of current safeguarding procedures and their responsibilities if they suspected abuse. One staff member said "There's more to abuse then physical harm. Poor care is abuse too." Staff were able to describe different types of abuse, signs to look for that might indicate abuse and the actions they would take if they needed to raise a concern. Care records confirmed that safeguarding alerts were made appropriately and the registered manager had oversight of these.

People told us that they were supported to take risks and were involved in the decision making process when risks were identified. For example, one person described how they had fallen when out at a local shop, saying "I thought that's it, I just can't go out any more, I'm not safe." Following this incident their care plan was reviewed and the risks were reassessed. They described how their views had been taken into account and despite the considerable erosion of their confidence staff had worked with them to enable them to begin to go out regularly with support.
Risk assessments were undertaken and advice was sought to minimise identified risks. For example, a person was assessed as at high risk of developing a pressure sore, pressure relieving equipment was put in place and advice was sought from the Tissue Viability Nurse to inform the care plan and prevent skin damage. Staff had a good understanding of risk management and keeping people safe whilst not restricting their freedom. One staff member said "Some of the people here are living with dementia but that doesn't mean we restrict everything they do," another said, "Keeping people safe is important but it's not everything." Staff explained how they supported people who had behaviour that could be challenging by identifying possible triggers or trying to de-escalate situations. One staff member described the importance of taking an individual approach to people saying, "I know that if I approach a particular person first thing in the morning I will not get a good response and they might react badly so I wait until later in the day." Incidents and accidents were recorded appropriately and actions were taken where possible to reduce the risk of reoccurrence. One example showed that a person who liked to smoke cigarettes had suffered a minor cigarette burn, the risk assessment was revised and the care plan was changed to prevent a similar or more serious burn and staff were aware of the changes.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. People and visiting relatives told us that there were enough staff, one person said, "Staffing levels are good now, much better than they were," another said "Staff are still busy but they make time, I have never felt rushed by anyone." A relative told us that they visited regularly and considered staffing levels to be good, saying "There are eight regular staff in the (dementia) unit and they are really familiar to us and to (person's name), we know some better than others but they are all good at what they do." Some people said that there were too many agency staff on duty, one person said "I really need regular staff because it can be painful when they move me, I used to have the same carers on a consistent basis but now I seem to get one regular carer and one agency person." Another person said "There are a lot of agency staff, they are pretty good but it's not the same as having regular staff who get to know you." Staff told us that there were enough staff, one staff member said "There are plenty of staff, I wish more of them were our staff rather than agency but it's ok," another staff member said "We do have enough staff most of the time, I can spend time with residents," and a third told us "I think we are going to get more permanent staff."

Staffing levels were consistent and the provider made extensive use of both existing staff and agency staff to cover vacant shifts. The registered manager confirmed that they used a dependency tool to determine the number of staff required and that agency staff were used regularly. They explained that this was in part due

to the expansion of the service over the previous 12 months and that although a recruitment programme was in progress there was still a need to use agency staff on a regular basis. The registered manager said that they only used one agency and tried to maintain continuity by booking the same agency workers. They also explained that agency workers were only used in the dementia unit if they had received training in dementia.

Staff records showed that appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for six staff members. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people. There were also copies of other relevant documentation including character references, interview notes, Nursing and Midwifery Council registration details and copies of identification documentation, such as passports in staff files.

People were protected from risks of acquired infections with robust infection control procedures. People told us that they felt the home was clean and hygienic, one person said, "The place is really clean, I have to keep things tidy in my room because they are in every day wiping the surfaces down." Other people and visitors all told us that the home was clean, that rooms were cleaned daily and staff wore gloves and other protective clothing when providing care, our observations confirmed this. We noted that every member of staff washed their hands and put on an apron before serving food at lunch time. We noted all areas of the home were clean, tidy and smelt fresh. There were parts of the home designated 'hand sanitising zones' which contained sanitising dispensers and notices to visitors explaining their relevance. We noted linen baskets were colour coded to avoid mixing soiled items with general laundry. The staff we spoke with told us supplies of continence products and personal protective equipment were plentiful and readily available. We were told there were some shortages at the beginning of the year due to problems with a supplier but those issues had been resolved. Staff displayed a good working knowledge of infection control and 83% of all staff had undertaken training in this area within the past year. The home had a nominated infection control lead with overall responsibility for the management of infection control.

There had been two infection control audits undertaken recently. One was a self-assessment tool provided by the Infection Prevention Society; the second, more detailed audit was conducted internally. We noted this was relevant and person centred. If issues were identified, a time scale for completion was set, along with a responsible person and a checking date. We discussed infection control issues with the Head of Housekeeping. We were told there were enough staff and equipment to maintain a clean environment at present, but that more domestic staff would be required as the home expanded.

Requires Improvement

Is the service effective?

Our findings

People told us that the care they received was effective and that staff were knowledgeable and confident in their roles. One person said, "I think it is excellent here, the best care I have had in my life," another said, "The staff are well trained, they all work really hard." A relative said, "The staff are well trained and they seem to have a genuine interest in dementia, they sometimes tell me about the training they have done and all the different aspects of dementia that they learned about." Despite these positive comments we found some areas of practice that required improvement.

The home had a policy in place to guide staff in procedures relating to 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisation to deprive a person of their liberty were being met. Staff were able to demonstrate a good understanding of the MCA including the nature and types of consents, people's right to take risks and the necessity to act in people's best interests when required. Staff had undertaken recent training in this area. One staff member described the principles of the MCA as "Encouraging people to make their own decisions" and "Not forcing someone to do something that they don't want to do." People's records included signed permission forms giving their consent to care and treatment and where people might lack capacity or had fluctuating capacity mental capacity assessments had been documented. We observed that staff frequently checked that people were consenting to their care, for example a staff member was heard to say, "Shall I cut the food up for you, would you like me to help?" and another staff member asked "Would it be ok if I check your oxygen levels now? It won't take long." Staff were seen to wait for the people to consent before helping them.

The home's MCA policy included a detailed summary of the provider's responsibilities with regard to making best interest decisions where someone may lack capacity. However, practice was inconsistent in this area. One person, who was living with dementia and was subject to a DoLS authorisation, appeared to have fluctuating capacity. There were bed rails in place but there was no mental capacity assessment or evidence of the best interest decision making process in relation to the use of bedrails. This matter was brought to the attention of the Registered Manager who took steps to ensure that this was rectified immediately. Six people were subject to DoLS authorisations and DoLS applications had been submitted for another six people. None of the staff members that we spoke with could tell us about the implications of DoLS for the people they were supporting. These are areas of practice in need of improvement.

People told us that the food at Lindridge was good, comments included, "You get a choice of meals, I have

pureed food and it's wonderful, I can taste every part of it," and "The food here is great, If I fancied something else they would do it for me, they would do cooked breakfast if you wanted it." Care had been taken to ensure that the dining area was pleasant with flower arrangements on the tables. The menu was displayed in the dining room and detailed two courses and desserts. A chef served the meals from a hot trolley, there were two hot options and the food was well presented and looked and smelt appetising. Staff checked that people were still happy with what they had previously chosen and offered them options if they appeared unsure about their choice. Staff noticed that one person had not eaten much, they were heard to offer support and encouragement saying "You should eat something, would you like a sandwich instead or is there something else you fancy?" The person accepted a sandwich which was brought straight away. We noted that a number of people had chosen to eat their lunch in their room and that staff were able to support them to do so. Staff were checking on people in their rooms and encouraging them to eat. The chef serving the food demonstrated a good knowledge of people's individual needs and preferences. For example when passing a meal to a care worker they said "This is for (person's name) they need it soft so there's extra custard, make sure you mash it for them," and "This one's a smaller portion for (person's name)." Most people were clearly enjoying the social atmosphere and their food, comments included "That looks really nice, thank you " and "This is lovely, who made it?" The chef and staff involved people in conversation throughout the meal and there was lots of laughter and chatting.

We observed the lunch time meal in three units. One person was sitting in the lounge area and had received very little assistance with their meal. Their care record included an assessment which stated 'Relies on others to be fed, ' and that they required a pureed meal. A risk assessment noted that this person was at risk of developing chest infections due to having an unco-ordinated swallow and dysphasia and that they had a history of chest infections. A Speech and Language Therapist (SALT) had advised that they should have a soft diet with modified food. However the file noted that this person had refused this advice and preferred to have normal food that had been softened with extra sauce. A mental capacity assessment confirmed that this person had capacity to make this decision. The care record contained contradictory advice for care staff, the SALT report stated that the person 'Should be supervised by staff when eating to ensure that they are well positioned and actively clearing their mouth between mouthfuls.' However staff were not aware of the identified risks and lack of guidance in the care plan meant that risks associated with eating and drinking were not being appropriately managed. We raised this matter with the registered manager who acknowledged that this was an area of practice that needed to improve.

Staff told us that "There's a lot of training on offer," a training plan showed that there was a wide range of training opportunities for staff in subjects relevant to the needs of the people they were supporting. We noted that induction training was robust and some new staff told us that their experience of the induction process had been "quite intensive" and included shadowing experienced staff and time spent just getting to know the people living at Lindridge. All new care staff were expected to undertake Skills for Life Care Certificate. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working lives. Some training was also offered to the regular agency workers including dementia awareness and manual handling training. This meant that people were supported by staff who had the knowledge and skills to meet their needs.

Staff told us they were well supported in their role and that they received formal supervision and appraisals from their manager. Supervision is a formal meeting where staff members can discuss training needs, reflect on their practice and receive support from their manager. Supervision should be a useful tool for managers to address performance issues and to provide support to staff. One staff member said, "I can say what I want in supervision and I will be listened to," another staff member said, "It's really open and honest. The manager is very straight forward". Records confirmed that supervisions and appraisal had been undertaken and were planned in line with the provider's policy. The registered nurses received clinical supervision from

the registered manager who was a registered nurse.

The registered manager explained that there were a number of staff meetings held regularly and arranged according to the area of the home that they worked in most regularly as well as general staff meetings open to all. We saw the minutes of these meetings showed that staff were able to discuss matters of importance to them and the people they looked after.

People were supported to maintain their health and to have access to healthcare services. One person told us "If I need the doctor, I can see him." A person who had mental health problems as well as physical disabilities told us that staff were proactive in ensuring that their health needs were met, they said, "The carers are really good at noticing if I'm not feeling well and they get the nurse to come and speak to me." Their care record contained details of the person's mental health, including signs that might indicate a relapse and a mental health care plan that had been regularly reviewed. We saw that an appropriate referral had been made to a psychiatrist and the person told us that their medication had been changed as a result of this intervention. The relative of someone receiving short term care said, "They are definitely getting the care they need, they have a bed sore but the staff are treating it." A person living in the dementia unit told us that they were "Waiting for the dentist to give me some new teeth," and another person said, "They check your weight regularly and I'm waiting for some physio." This showed that people were supported to access the health care services they needed.

We observed that staff were proactive in monitoring people's health for example, a nurse was seen checking someone's oxygen levels as care staff had reported that they had been breathless that morning. A person was heard telling a care worker that they were in pain and within a few minutes the nurse came and spoke quietly with the person before offering them some pain killers. A relative told us "I know they check warfarin levels regularly." Care records showed that staff were effective in monitoring people's health for example a person with diabetes had a diabetes care plan, their weight and blood sugar was regularly monitored and a nutritionist had been consulted for advice about a weight reducing diet. Some people had a hospital passport in their file to assist in providing the hospital staff with important information about the individual if they should be admitted to hospital. Numerous interventions were documented with health care professionals showing that referrals were made appropriately and in a timely way when people's needs changed. One visitor told us "The care here has been fantastic, they were really poorly but we have seen a vast improvement in their health since they came here," another relative said "I really think the standard of care here has prevented my relative from passing away and, in fact, has brought my relative's health around."

A high proportion of the people living at Lindridge had physical disabilities. The building had been extended and refurbished in the previous 12-18 months to accommodate more residents. We checked how their individual needs were met by the design, adaptation and decoration of the home. All areas of the home were decorated and furnished to a high standard. The home was divided into different zones, people with physical disabilities were mainly accommodated on the ground floor, those living with dementia were in a separate area on the ground floor and people requiring short term care were accommodated upstairs. The home had been designed to accommodate people who used wheelchairs and a lift provided access to the upper and lower floors. People told us that they were able to access communal areas with ease, one person who used an electronic wheelchair told us "I can get around easily, I go out in the garden too, in the front they have raised beds which is good for people in wheelchairs. The bedroom door is a bit tight but I am getting better at driving (the wheelchair)." During a church service held in one of the lounge areas we saw that there was room to manoeuvre wheelchairs so that everyone could be included in the service. We noted that people using wheelchairs were supported to bring them up to tables in the dining area enabling them to be included in the lunchtime meal and to be fully involved in an activity session during the afternoon.

People told us that they were able to access their ensuite bathrooms effectively and they could choose how they wanted their bedroom arranged and decorated. One person using a wheelchair said that they would like to move to a larger room with more space and they were waiting for the registered manager to tell them if this would be possible. There were four flat-lets on the ground floor that were designed to maximise people's independence. The registered manager told us that one person who was of working age had been able to maintain their independence and work from the flat-let until the time of their death. Staff told us, and we observed that there was adequate equipment in place to support people with transfers to and from wheelchairs. We observed people being transferred and saw that staff were confident and competent in the use of the equipment. People told us that the environment was well designed for their needs, one person said "I couldn't manage at home any longer but I can be reasonably independent here because its well set up for my needs," another person said, "Sometimes I get very depressed and anxious but living here had helped because the environment is lovely, its clean and bright and my room is quiet which is what I need. I sometimes take myself off into the garden because it's peaceful and I need a calming atmosphere."

We noted that lounges were arranged with clusters of chairs to maximise space and provide a more homely atmosphere. One person told us that when they had several visitors they liked to use a lounge area because there was more room, they said, "When it was my relative's birthday I was able to hold a little party for them here, it was a lovely day." Consideration had been given to the needs of people who were living with dementia. For example, a wall- mounted screen had been adapted to give the appearance of a television from the 1950's and the images it displayed were also of that era, staff said this was designed to stimulate pleasant memories for people. There were also various small items, books, beer mats and memorabilia around for people to pick up, staff said this provided interesting conversation topics for people.

The garden could be accessed through the lower ground floor and staff told us that people did come down in the lift to use the outside space when the weather was nice. We found that there were some trip hazards on the garden path including a piece of metal that was embedded in the path. This was mentioned to the registered manager who has informed us since the inspection that this has been removed. Staff told us that there were plans to improve the garden facilities including the siting of a log cabin that could be used flexibly as either a pop-up pub or country kitchen depending upon what people living at Lindridge wanted. There were also plans for a post box to be sited in the home for people's use.

Good

Is the service caring?

Our findings

People told us that the staff were caring and spoke highly of the support they received. Comments included, "The carers are fantastic," "The staff are friendly, kind and attentive," and "Everyone here is kind." Relatives also described the caring nature of staff saying "The care here is 100%," and "Staff are welcoming, kind and caring, we couldn't want more," and "The carers are wonderful." One relative said "The nursing has been exceptional, they are very caring, genuinely affectionate and they are always jolly and interact with the residents."

We saw that people were comfortable with staff and throughout the inspection we noted warm and friendly interactions between staff and the people they cared for. One person said "The staff are happy inside and they make me happy too." Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. We saw a person asking a staff member if she could have a drink and this was brought straight away with a smile. Someone was heard to tell a member of staff that they had a headache, this information was shared with the nurse immediately and they were seen talking to the person, demonstrating empathy and providing a drink and medication very quickly. Another person was seen to be in distress in their bedroom, a member of staff realised something was wrong and went to their assistance immediately. They were heard talking gently to the person in a kind and reassuring way and they stayed with them for ten minutes before leaving them when they were relaxed and peaceful. We observed that staff were consistently allowing people time when providing care, for example one staff member was heard to say, "Take your time, there's no rush we've got all afternoon if you want." People told us that their views were taken into account, one person said "I don't mind who looks after me but I'm sure they would let me have the right gender of carer if I did." People told us that call bells were usually answered quickly, comments included "Normally they respond to a call quickly," and "The staff are friendly and helpful, the response to a call is quite quick." We noted that people living in the dementia unit did not have call bells in their rooms, staff told us that they didn't need them because staff were constantly checking people and responded quickly when someone was in distress. We saw that this was happening and a relative told us that staff were "Very attentive."

Staff demonstrated that they knew people well and had developed relationships with people. One person told us "Staff know me well, they are very nice and help me a lot, even the office staff are lovely." We observed staff sitting and chatting with people and suggesting plans for later in the day, one said "I've brought in some large playing cards, perhaps we could have a game later if you want to?" People told us they felt listened to, one said "I was involved in developing my care plan and so was my brother, I know the staff listen to me and I can change things if I want to."

We asked about how people with communication difficulties were supported to express their views about their care and treatment. Staff told us about one person who had a learning disability and how they had developed a close relationship with their key worker. A key worker is a named member of care staff who takes a lead and special interest in the care and support of the person. The care plan for this person clearly described their needs and preferences and indicated where they were able to make decisions about their care and where they may need support to do so. For example there was a specific care plan for

communication and this indicated that that the person could understand some Makaton signs, could use a pictorial communication book and was able to understand most things that were said as long as they were given time to assimilate the information. Staff told us that they used these approaches to ensure that the person was actively involved in making choices and decisions about their daily life.

People's privacy was maintained, their confidential records were kept in locked cabinets and staff were aware of the importance of maintaining confidentiality, one staff member told us "We have to be careful not to talk about people's personal circumstances with other service users." People told us that staff treated them with dignity and respect, one person said, "The carers are really respectful, they always knock on the door and wait for me to tell them to come in," this was evident in our observations throughout the inspection. Another person said, "They do treat me with respect and maintain my dignity, they shut the door and pull the curtains before attending to me." Relatives also told us that staff were respectful, saying " Staff speak to people in a respectful way and really mean what they say, they never keep people waiting for something if they ask for it, and I have never seen anyone with dirty clothes or food stains, they are well cared for here." Relatives told us they were always welcomed and staff offered them drinks when they visited. One person said "My friends and relatives visit at all times, no one minds, they have come to lunch or supper sometimes, they're made welcome whenever they come."

Good

Is the service responsive?

Our findings

Staff were responsive to the people they were supporting. Care records were clearly presented, well personalised and showed that people had contributed to their development. People and relatives told us that there was a focus on individual needs and that they were included in the review process. People's comments included "I am definitely getting the care I need here," and "The family have been involved in the upkeep of the care plan." We asked staff what they understood by the term person centred care, they said "It's putting people at the centre of things," and " We give people the care we would want for our own parents or grandparents, we get to know people really well." We noted that staff displayed a thorough knowledge of the people they were looking after and were able to talk in detail about people's needs and their preferences.

Most records had a life story section with information about people's past, their hobbies and interests, likes and dislikes, their appearance and important events in their life. A relative told us that staff worked hard to maintain people's identity saying "People here are still who they are." Records were detailed and gave a sense of the person and what was important to them, for example, one person's care plan stated 'I have lots of jewellery that I like to choose and wear every day' and 'I enjoy having my nails painted and my hands massaged.' One person told us that they enjoyed playing scrabble and we noted that this was recorded within their care record as an interest of theirs. We asked a member of staff why some parts of the life history section in a care plan were not complete, they explained that it was because the person had chosen not to complete them or because the person couldn't remember and there was no family members to ask.

People were supported to follow their interests and there was a varied activity programme available arranged by two activities co-ordinators. People told us that they had enough to do, one person said "There is a fortnightly activities sheet, there is enough to entertain you," another told us "I like to go and see what's on sometimes." Relatives said "There seems to be enough to do and (person's name) join's in." We asked staff how they prevented people from becoming isolated in the home. One staff member said "We encourage people to take part in activities but we also spend time with people in their rooms," the activity co-ordinator said "We make sure we spend time with people in their rooms on a weekly basis if they are not able to get out of bed." One person told us that the activity co-ordinator visited every day.

Special events were planned and we asked the activities co-ordinator how people's views and interests were taken into account. They told us "We spend time talking to residents, visiting them in their rooms and we learn about them from their family and other staff. We explore ways of entertaining the residents, it's through trial and error." Some examples of popular activities had included trips out where one to one support was offered, and visits from farm animals in the winter months. On the day of the inspection people told us that there was a science theme and the activity co-ordinator was seen supporting people to build volcanoes as part of an experiment. A child was visiting and was also invited to join in with this activity which was clearly a source of enjoyment and interest for the people taking part. Staff in the dementia unit also planned some activities and we saw that there was a range of items readily available to support communication and engagement with people living with dementia. This included items that could be used for reminiscence and a box of materials with different colours and textures to provide tactile interest for

people. One person, who was living with dementia, expressed a desire to attend a church service, there was one taking place on the day of the inspection but they had not been told about it. Staff said they were unaware that the person might want to go and there was nothing in the care plan to indicate their wish to attend however staff took immediate action to note this and gave assurances that they would offer the opportunity to attend in future.

We asked people and relatives how staff responded to changes in people's needs. One person with a physical disability told us that having consistent care workers was very important, particularly when being supported with manual handling techniques. They said that the registered manager had ensured that at least one member of the two carer team was familiar with their care to ensure a consistent approach and to prevent deterioration and increased pain levels during repositioning. A relative of a person in the short term care unit said, "The staff are very professional, they have made (person's name) better within a week of being here." Another relative told us " The staff tried to keep my relative walking for as long as possible, when they couldn't manage anymore they changed things around to make it easier, the staff are so familiar with people's needs ." Staff told us and we saw that there was a system in place to support staff communication regarding any changes in people's needs. This included written handover sheets noting information of relevance such as people's physical or psychological state and any changes identified. Senior care staff also passed on information from the previous shift to ensure good continuity of care.

People and relatives told us that they would feel comfortable making a complaint and that they knew how to complain. Most people told us they had not had to make a complaint, comments included "I've never complained, I tell them what I like and what I don't," and "I've had absolutely no cause to complain, if I did, I would," and "I've never had to make a serious complaint but if I did I'm sure they would sort it out straight away." A relative also told us "We've no complaints." We saw that there was a complaints and compliments record in use and that some complaints had been recorded and were responded to appropriately.

Good

Is the service well-led?

Our findings

People, visitors and staff spoke highly of the registered manager and described the culture of the home as being open, person centred and empowering. One person said "I don't think the management could be better, I'm very happy here," another person said, "The home is run pretty well," and a third person said "The manager is approachable and the senior staff are all lovely." A relative described the staff team as being "Very open, and ready to listen," another relative said, "This is a well- managed home."

People and relatives said that they felt able to raise any issues or concerns and had confidence that their comments would be listened to. People and relatives told us that they were able to contribute to the development of the service and that the needs of people living at Lindridge was given priority when looking at improvements. A staff member said, "We want to make this place work for the people who live here," an example of this came from a relative who told us how the staff had supported their family with bereavement. Staff supported their relative, who was living with dementia, to attend the funeral. Arrangements were made to hold the wake at the home. This enabled the person to remain central to the proceedings whilst being supported in familiar surroundings.

We noted that staff had made a number of links with the local community, for example, the minister from a local church held a regular service at the home and this was well attended. The registered manager told us that they had developed good links with the local hospice and we saw that some people were being referred to the home for end of life care. A specialist Parkinson's disease group held meetings at the home and provided training for staff. We saw that external health and social care professionals visited people at the home on a regular basis.

Staff were supported within their roles by a clear management structure which included a deputy manager, three clinical leads and two team leaders. Staff told us that the Registered Manager was approachable and that they felt the home was well led and had an open culture where issues could be raised and discussed in a transparent way. Their comments included, "The manager is really good, and fair too," and "I can speak to the manager but I usually go to one of the nurses first." Staff were well motivated, one member of staff said "It's about providing a home from home, " another said, "We try hard to offer individualised care," and a third said " A normal life, that's what we're here to provide." Staff told us they enjoyed their job, one said, "As a carer I am very happy working here, I've been here some years now," another staff member said "I love it here. This is the best job in the world," and a third told us "I've worked here a long time, I wouldn't stay if I didn't like it, it's a happy home."

People's experience of care was monitored through a range of quality assurance systems. There were a number of internal and external audit tools used to gather data and information on quality. For example, the registered manager had undertaken an audit in November 2015 to identify areas for improvement across the home. This has included sampling care plans and observing care given. We saw that this audit had identified some areas for improvement for example detailing people's preferred daily routine and that this had been included in an action plan. We noted that a number of audits were undertaken on a regular basis to ensure the manager had oversight of quality issues. There was a system for recording and monitoring

incidents and accidents and recording what action was taken as a result of learning from such incidents.

The registered manager told us that the home was now entering the final phase of its redevelopment with the imminent opening of a new unit for people with mental health problems who sometimes displayed behaviour that could be challenging to others. The Registered Manager said that recruitment was in progress and that although the unit was ready for people to move in they would not begin taking referrals until the staff team was in place and adequately trained to provide the care needed. A relative of someone living in the dementia unit told us "The number of people living there has grown. We have been impressed with how well managed it is, they brought people in slowly and I think they got the balance right." The registered manager told us that the intention is to take a similar approach with the new unit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the unsafe use and management of medicines.