Maureen Philomena Murphy & Ann Catherine Smith

Lindenwood Residential Care Home

Inspection report

208 Nuthurst Road
New Moston
Manchester
Greater Manchester
M40 3PP

Tel: 01616814255
Website: www.lindenwoodcare.co.uk

Date of inspection visit:
05 October 2017

Date of publication:
17 October 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an announced focused follow up inspection, which took place on the 5 October 2017. The inspection was announced to ensure that the registered provider and registered manager would be available to assist with the inspection visit.

Lindenwood is located in the New Moston area of Manchester. The home provides accommodation and personal care for up to 16 people and has 13 bedrooms.

The service was last inspected in April 2017. At that inspection we rated the services requires improvement. This was because we found two breaches of the regulations relating to risk and on-going monitoring. These related to the risk assessment of one person that required additional information to be added to ensure the person's best interests had been considered and that there was clear guidance in place to ensure that staff took the correct action should an emergency situation arise. We also found a number of risks when we looked around the premises relating to the Control of Substances Hazardous to Health (COSHH) and the build-up of unwanted combustible items in the outhouses and storage areas. Because action had not been taken to register a manager with us in a timely manner we had also placed a limiter on the rating in the well-led section of the report of requires improvement.

Following the inspection in April 2017 we received an action plan from the provider which informed us of what action they intended to take to make the necessary improvements to the service. At this inspection we checked to see what action had been taken to address the breaches in the regulations which are the fundamental standards. We found that improvements had been made.

We found that the registered provider had taken swift action to register a new manager following our inspection. 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.

We found that action had been taken to protect people who use the service and others against the risks associated with the individual care of a person and unsafe or unsuitable premises.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

We found that improvements had been made to protect people who use the service and others against the risks associated with the individual care of a person and unsafe or unsuitable premises.

Is the service well-led?

Good

The service was well led.

To comply with the conditions of the services registration there was a manager in place who was registered with the Care Quality Commission.

The registered provider and the registered manager confirmed that they had a good working relationship and had taken action to ensure a consistent approach in the day-to-day management of the home.

Lindenwood Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 5 October 2017 and was announced. The registered provider and the registered manager were given notice before our inspection so we could be sure they would be available to discuss the improvements they had made. The inspection team consisted of one adult social care inspector.

During the inspection we spent time talking with the registered manager, one of the registered providers and two relatives. We looked at documentation related to the running of the service and looked around parts of the home.

Good

Is the service safe?

Our findings

At our last inspection we found that people had new care plans and risk assessments and there were systems in place to ensure that the records were kept under review. However, we reviewed one risk assessment that identified a person had refused a medical intervention to help them with their nutritional intake but had accepted an alternative method which potentially put them at risk of choking. This person had capacity to make this decision and was aware of the risk. A best interest meeting had taken place, the appropriate health care professionals had been involved in this person's risk assessment, and this was recorded in the person's care file. However, we did note that the person's risk assessment needed further direction for staff relating to the risk of choking should their initial response to the situation fail and assistance was required from the emergency services.

At this inspection the person's risk assessment had been updated to direct staff to contact the emergency services in the event of an emergency occurring. The registered manager told us that a keyworker system had been introduced. It was part of the person's key worker responsibility to review the persons care and records monthly to ensure it was accurate and the registered manager would audit them every three months.

At our last inspection we found that chemical substances such as bleach and hard service cleaners had been left unattended leaving people at risk. This was a breach of the Control of Substances Hazardous to Health (COSHH). We also saw many unwanted items both inside the house and outside in the garden and outhouses. A mixture of combustible materials and electrics in the outhouses is a potential hazard. We saw that at times the door to the laundry, which is a hazardous area in terms of fire safety as well as for people who lack capacity, was left open and accessible. We also noted that a linen storage cupboard, which could not be kept locked shut, was close to an escape route. Linen should be stored in a locked shut cupboard and away from an escape route to reduce the risk of a fire. New commodes had been purchased for people who needed them. However, the lack of a sluice room in the home made it difficult for the staff to clean the commodes.

At this inspection the registered manager told us that they had taken disciplinary action in relation to COSHH safety and a new COSHH risk assessment was in place. The registered manager told us that they had also sourced new and appropriate cleaning products to help improve the prevention and control of infection at the home. The registered manager told us that there was a new housekeeper in place and we noticed a visible improvement in the appearance of the home. The registered manager had also sourced a new training provider. The home was using workbooks for training that were externally verified to help ensure the staff member's competence, including COSHH.

We walked round parts of the building and the garden. We saw that significant improvements had been made in removing unwanted items both inside the house and outside in the garden and outhouses. We saw that cleaning products were being stored in a metal shed in lockable metal cupboards. We saw that a brick outhouse had started to be prepared which would eventually become a cleaning storage area.

We saw that the laundry was kept locked shut and that the linen store had been emptied and was now storing activity equipment. The registered manager told us that people's individual linen was kept in their rooms. New commodes had been purchased for people who needed them. However, the lack of a sluice room in the home made it difficult for the staff to clean the commodes. The registered manager told us that plans were in place to remove one of the two assisted baths and create a wet room/toilet. This would mean that one of the other two toilets could be used to create a sluice room for staff to use.

The registered manager told us that they carried out a daily walk round the home to help ensure that staff followed health and safety measures that they had put in place. They said that staff were reminded to follow the measures if needed. However a decision had been reached that in future disciplinary action would be taken for repeated failings to follow health and safety direction and staff had been informed of this at a staff meeting in September 2017.

We saw that the registered manager had put the Personal Emergency Evacuation Plans (PEEPS) into a grab file and had put in place a night evacuation risk assessment.

During our conversation and review of records it was clear that the registered manager demonstrated the importance of health and safety procedures. A new generic risk assessment had been put in place for the home.

During our walk round we spoke with two relatives. They said, "[Relative] is alright. [Relative] is well looked after and is happy and we are happy. Any problems and they will let us know."

Good

Is the service well-led?

Our findings

At our last inspection we found that the service did not have a registered manager in place. Because action had not been taken to register with us in a timely manner, we placed a limiter on the rating of the well-led section of this report of requires improvement. We reminded both the registered provider and the then manager that is was a condition of the registration of the service. Shortly after our inspection the manager resigned from the service. The registered provider took swift action to appoint one of the two deputy managers at the home as the manager and they are now registered with the Care Quality Commission.

We were told that following the inspection the management team was under review. There was no longer a deputy position. Two senior staff who worked on opposite shifts to each other so that there was now better management oversight at the home had replaced the deputy.

At the last inspection we saw that systems had been put into place to evidence that there was on-going monitoring of the service. We saw a health and safety inspection checklist and monitoring checklist, which covered a wide range of health and safety issues, as well as falls, accidents and incidents. However, the systems in place had not identified all the shortfalls we found during our inspection as we found a continuing breach around risk.

We had received an action plan from the provider telling us what action they intended to take to make improvements. We found that improvements had been made in health and safety at the home as identified in the safe section of this report.

At the last inspection we found that there was a lack of clarity about the roles and responsibilities of the registered provider and the manager. A good working relationship between the registered provider and the registered manager is essential to ensure the consistency in the day to day running of the home. We talked with the registered manager and the register provider about their relationship. They told us that they had worked together for many years and knew each other well. They told us that there had also been changes in the staff team since our last inspection visit and that along with the change in the management structure this had a positive affect and had improved staff morale.

The registered manager said that they had better working relationships with external health and social care professionals and had sought advice from a range of health and safety professionals and actioned any recommendations they had made.

We asked for information about any improvements that had been made at the service since our last inspection. We saw that there were plans in place to make improvements to the premises. We saw information that showed that the service was working in partnership with the North Manchester Home Intravenous and Sub-Cut Fluids service. Should the home suspect that a person had contracted an infection this service would come into the home to treat the infection to help prevent the person going into hospital. The home had also enrolled with MacMillan nursing staff who were going to come into the home to carryout end of life care training with the staff.