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:
03 December 2018
04 December 2018

Date of publication:
23 May 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Lindenwood Residential Care Home on 3 and 4 December 2018. The first day of the inspection was unannounced.

Lindenwood Residential Care Home provides accommodation and personal care for up to 16 older people, some of whom were living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were 16 people living at the service at the time of our inspection.

We last inspected Lindenwood Residential Care Home in July 2018. At that time, we found one breach of legal requirements and the home was rated 'requires improvement' overall. We had scheduled a date to return to Lindenwood Residential Care Home to check on progress. However, in the intervening period since our last inspection, CQC received information of concern that was of a safeguarding nature. In response to this, we raised a safeguarding alert with the local authority and brought forward this scheduled inspection.

We are currently considering our options in relation to enforcement and will update the section at the end of this report once any action has concluded.

At the time of this inspection there was a manager, however they had not yet registered. 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. The previous registered manager had left in November 2018 which the service had notified us of. The service has had several management changes over the previous two years. Shortly after our inspection the provider contacted us to say they had dismissed the manager. The provider confirmed they were actively seeking to recruit a new manager for the home.

We were not assured that systems and process for safeguarding people who used the service from abuse were operated effectively. We looked at the concerns raised and found the provider had not protected people from the risk of harm and abuse. CCTV footage had shown that four care workers were sleeping on duty. The provider had not taken timely decisive action. Furthermore, we found the provider had failed to make safeguarding referrals to the local authority and CQC had not been notified in line with regulatory requirements about this matter.

There had been multiple whistleblowers to CQC since our last inspection. Issues raised included concerns about new care workers not being recruited safely. We found the provider did not have robust recruitment procedures in place to ensure staff employed were of good character and to consider any potential risks in relation to their employment, as we found five staff had been working at the home without a Disclosure and Barring Service check (DBS).

People within the service were not always safe. During our tour of the home we found the fire exit was partially blocked by a stand aid and we found the lounge door presented a danger due to the door automatically swinging closed after 15 seconds. We found no evidence to show the homes passenger lift had been examined to ensure it was safe to use under the 'Lifting Operations and Lifting Equipment Regulations' 1998 (LOLER).

Although staff we spoke with said there were enough staff working in the home, we were not assured there were always sufficient numbers of staff deployed to meet people's needs at all times.

The management of medicine was not always safe, which put people at risk. We found inconsistencies in respect of record keeping and we found people did not always have detailed guidance in place for 'when required' medicines.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way. They did not always respond appropriately and in a timely manner to people's needs.

Staff were not always working within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments for specific decisions had not been completed and correct legal authorisation had not been sought to deprive people of their liberty.

Accidents and incidents were not always recorded, and appropriate analysis was not undertaken to look for trends to try to prevent future accidents.

People had access to health care professionals specific to their needs. However, we found missed opportunities to provide people with the appropriate advice and support when they were losing weight.

Care plans were difficult to navigate which meant that new staff or agency staff may not easily find the most up to date information on people's care needs. Staff had received training in relation to their role and had the opportunity to meet with their manager. However, we found care staff needed training in managing behaviours that challenged.

Throughout the inspection, we observed numerous examples of positive and caring interactions between staff and people who used the service. However, opportunities for such interactions were limited as staff primarily focused on the delivery of task-based care. Activities were not always person centred and people did not have appropriate opportunities to go out.

Although we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected. We have made a recommendation that the service consults the CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.'

Complaints were recorded and responded to. The provider had a complaints book that recorded verbal complaints.

The provider was unaware of their responsibilities in relation to the duty of candour, which requires services operate in an open and transparent way. We also received evidence that staff within the service had not always acted open and transparently in relation to issues arising in the service, such as staff sleeping on

duty.

There was a lack of leadership and governance at the home. There was a lack of support and coaching for staff and this was reflected in the care they provided. Auditing systems were not robust enough to ensure that the service was compliant with the Health and Social Care Act 2008 and as a result these had not identified the concerns that we found during our inspection. The provider had also failed to notify CQC of important incidents and events.

The overall rating for this service is 'Inadequate' and the service has been placed into 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding procedures were not effective at the home to protect
people from potential abuse.

The premises were not maintained to a safe standard. We found the fire exit was partially blocked, and the passenger lift had not received a thorough inspection.

There were not enough staff to safely meet the needs of people. Staffing levels were not set according to people's needs.

We identified ongoing concerns in relation to the safe management of medicines.

Is the service effective?

Inadequate

The service was not effective.

Best interest's decisions had not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

People had access to health care professionals specific to their needs. However, we found missed opportunities when people were losing weight.

Staff told us they considered there to be sufficient opportunities for training and on-going development. However, training in managing behaviours that challenge was required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in planning their care or supported to make choices relevant to their needs.

Staff interactions were caring but were often task orientated.

Staff did treat people with dignity and we did see occasions

where staff were kind and attentive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not sufficiently detailed and did not give the staff the information they needed to care for people in the way they liked.

People had limited access to activities.

People who used the service and visiting relatives told us they knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and governance at the home. The provider did not have oversight of the service. There was not a positive culture within the service to ensure the delivery of person-centred care.

The provider had not reported safeguarding incidents to the Care Quality Commission.

Staff within the service had not always acted in an open and honest way in their handling of incidents. The provider was unaware of the requirements of the duty of candour regulation.

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.

This inspection took place over two days on 3 and 4 December 2018. The first day was unannounced, which meant the service did not know in advance we were coming. The second day was by arrangement.

A planned inspection of Lindenwood Residential Care Home was brought forward in response to information of concern received by the Care Quality Commission (CQC). These concerns were of a safeguarding nature. The inspection team comprised of two adult social care inspectors.

Due to the timeframe in which this inspection was completed, a Provider Information Return (PIR) was not requested to support us with our inspection planning. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we reviewed information we already held, in the form of statutory notifications received from the service, including safeguarding incidents, deaths and serious injuries.

Due to the nature of the service provided, some people were unable to share their experiences with us; therefore, we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot talk with us. In addition to this, we spoke with six people who used the service and two visiting relatives.

We also spoke with six members of staff, including the provider, manager, one senior and three care workers. We also spoke with a visiting professional from a local authority. We looked in detail at four care plans and associated documentation; five staff files including recruitment and selection records; training

and development records; audit and quality assurance; policies and procedures and records relating to the safety the building, premises and equipment. We also reviewed records relating to the management of medicines at the home.

Inadequate

Is the service safe?

Our findings

Safeguarding procedures were not followed appropriately. During the inspection we were advised by the home manager that the they had identified four night care workers sleeping on duty on two consecutive nights. These care workers were found on the provider's CCTV footage to be sleeping in the lounge for approximately four hours during the early hours of the morning, when in fact they should have been providing support to people throughout the night. This meant people who required to be repositioned every two to three hours, to minimise the risk of pressure sores, had not been repositioned. Furthermore, we found the care workers on duty had also falsely written in people's daily notes to say these tasks had been undertaken, when in fact this was not the case. We found one staff member had been dismissed by the provider, but immediate action had not been taken against this staff member. This meant they worked another three-night shifts even though the manager and provider were aware they had been sleeping on duty. We found no action had yet been taken against the other three care workers. We found two of the care workers had worked six and three times since they were found to be a sleep while on duty. The third member of staff was employed by an agency. Although the home reported their concerns to the agency we found no follow up had been made by the provider to check what action the agency would be taking.

In both instances, the provider had failed to make safeguarding referrals to the local authority and CQC had not been notified in line with regulatory requirements. It is an offence not to notify CQC when a relevant incident, event or change has occurred. The Manchester Safeguarding Adults Board Multi Agency Policy and Procedures states, 'A concern must be raised and reported immediately or no later than the end of the same working day'.

This demonstrates that procedures for investigating and acting upon potential safeguarding concerns were not operated efficiently to ensure the safety and wellbeing of people living at the home. During the inspection the manager made the required safeguarding referrals after we brought this to their attention.

The provider had not ensured people were protected from abuse and improper treatment in accordance with this regulation. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Service users were not always protected from being cared for by unsuitable staff because although recruitment processes were in place, they were not always followed.

Prior to our inspection we received whistleblower concerns that a number of newly recruited staff were working at the home without a Disclosure and Barring Service check (DBS). DBS checks provide details on any convictions a staff member has and helps employers make safer recruitment decisions. During the inspection we found evidence that confirmed staff had not been recruited safely. We reviewed five newly recruited staff files, which also included the home manager's recruitment file. In all five staff files we found no recent DBS checks had been obtained. We found the home manager made it their responsibility for recruiting these staff members and relied on their outdated DBS checks from the applicant's previous employment did not meet Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. We found all staff had also been working on duty since their appointments, which potentially put people at risk as the provider had not satisfied themselves that the staff employed were of good character. We also identified other areas of concern with the staff files, with references not being verified and gaps in employment history. During the inspection the manager started the recruitment process again for these staff members and removed them from duty until they received their DBS checks and references.

The provider did not have robust recruitment procedures in place to ensure staff employed were of good character and to consider any potential risks in relation to their employment. This was a breach of Regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff were aware of, and able to tell us how they would identify and report potential abuse or neglect. We also saw that safeguarding was a regular agenda item on team meetings, which would help staff maintain an awareness of the importance of recognising and reporting any concerns. Despite this, we found procedures in place to help prevent abuse occurring were not always robust.

There were 16 people using the service when we inspected, and accommodation was provided over two floors. The provider told us the usual staffing levels were one senior care worker and two care workers throughout the day and two care workers at night. These staffing levels were confirmed by the rotas we were provided with. Additional staff members were deployed as a cook and an activities co-ordinator who worked four days a week.

Although staff we spoke with said there were enough staff working in the home, we were not assured there were always sufficient numbers of staff deployed to meet people's needs at all times.

We found the provider did not use a staffing dependency tool to assess people's individual needs to calculate safe staffing levels within the home. We were not assured the staffing levels were sufficient to meet people's needs and there was no evidence to show people's dependencies and the layout of the building had been taken into account to ensure staffing levels were safe. We were informed by the provider and care staff that one person was known to display behaviours that challenge, with the potential to cause harm to other people. The additional support this person required had not been considered in relation to the staffing hours deployed and we found this person's whereabouts were not being monitored due to the insufficient staff numbers on duty.

On the second day of our inspection we found one person had difficulties with the automatic door located in the lounge. We intervened to help this person by holding the door, due to the door hitting the person as they were walking to the lounge. Due to no staff being in close proximity, an inspector from the Commission walked with the person to their chair to avoid the risk of the person falling.

Shortly after the inspection the provider sent us their action plan that detailed the staffing levels would be reviewed and provided assurances that they would ensure at least three care workers would be on duty during the day.

The failure to effectively employ a sufficient number of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received concerns that the passenger lift at the home was not safe. We were provided with a number of servicing reports, which confirmed the passenger lift had undergone a number of recent emergency repairs. We requested to view the Lifting Operations and Lifting Equipment Regulations

(LOLER) report, however the provider informed us they didn't realise the passenger lift required a LOLER inspection. The LOLER Regulations 1998 introduced new requirements for the safe provision and use of lifting equipment. Regulation 9 of LOLER requires that all lifts provided for use in work activities are thoroughly examined by a competent person at regular intervals. During the inspection the provider urgently contacted their insurance company, who were able to arrange a LOLER inspection for the passenger lift, on the second day of our inspection. We spoke to the lift engineer who undertook the LOLER inspection and we were advised the passenger lift was safe to use. Aspects of the passenger lift were still due to be repaired, such as fitting a new auto dialler lift emergency system, but these tasks were not considered urgent by the lift engineer and this did not compromise the safety of the passenger lift. The provider confirmed the outstanding work would be undertaken in the forthcoming months. We will review this at our next comprehensive inspection

During our tour of the home we noted several potential safety hazards. We found the lounge had an automatic door closure in place. The door would automatically close within 15 seconds when opened, which meant the door would close on a person if they didn't go through on time. During the inspection we observed the door catch one person, which nearly knocked them to the floor. Although this didn't cause an injury, there was a potential for a serious injury. We discussed this risk with the provider, who requested an engineer to look at the door, which the provider has confirmed no longer closes automatically after 15 seconds. We found the ground floor fire exit was partially blocked due to a stand aid equipment being stored inappropriately, which potentially compromised the safety of people in the event of an emergency.

Furthermore, we found the outdoor yellow clinical waste bin was unlocked and located at the rear of the home. We brought this to the manager and providers attention on the first day of inspection. We found the clinical waste bin was still unlocked on the second day of our inspection. The manager and provider had not considered the significance of ensuring this always remained locked when not in use. The Department of Health guidance states that: "Where the waste is stored for any period (that is, up to 24 hours), it should be stored securely, and access should be restricted to authorised and trained personnel." The provider had not taken reasonable steps to ensure the clinical waste bin was stored securely.

The provider had not taken reasonable steps to mitigate risks to the health and safety of service users. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments and care plans for people with behaviours that could challenge the service had limited information and did not provide detail about behavioural triggers or strategies to manage the behaviour. One person had a risk assessment for aggression. There was no information about what might trigger this person to be aggressive. We asked two care workers whether they had received 'breakaway' training and they said they had not. Breakaway training techniques are used in some services to prevent injury and manage potentially difficult situations. They told us they did not use physical interventions and their response would be to try and calm the person or run away if necessary. This meant that the person's personal safety and the safety of others could be put at risk. The provider confirmed shortly after the inspection they would be providing additional training the staff team in behaviours that challenge. We will review the progress of this at our next inspection.

During our inspection in July 2018 we identified improvements needed to be made in the management of medicines as we found the audits undertaken did not identify checks of the running total of medicines kept in stock. Although we found improvements in this area, we found further issues connected to the homes medicines.

At this inspection we found the management of the medicines at the home needed further improvements.

Medication administration records (MAR) were pre-printed or handwritten. For the handwritten records, the records of medicines, their dosages and administration instructions were not duly signed in by two care workers confirming the medicines were correct. Poor records are a potential cause of preventable medication errors. Printed MAR charts are not essential, but they are recommended as they are better than handwritten charts as there is less risk of any clerical error, such as incorrectly transcribing the details from another document and handwriting that is difficult to read and can be misunderstood. The NICE guidance 'Managing Medicines in Care Homes' states; "Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used." However, we found there was not a system in place to ensure service users medication details were verified for accuracy.

There were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN). Protocols give direction to staff as to how and when these medications should be administered, as they are not routine. This meant that staff may not be aware when a person needed medicine, such as pain relief, because there was no guidance to show how people communicated that they were in pain when they were unable to verbalise how they were feeling. For example, we found one person was prescribed paracetamol to be taken as required. There was no guidance for staff for when the medicines needed administering. Additionally, another person had recorded on the MAR two shop bought medicines to be used 'as required' but there had been no agreement with the GP, that these medicines were safe for the person to take.

Staff responsible for administration had received training in medicines. However, records did not evidence that these staff had their medicines competency checked. We were informed by the manager that they had not yet had the opportunity to undertake these tasks. However, we found previous competency assessments had not been undertaken during last 12 months. Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines.

We checked the arrangements for the storage, recording and administration of medicines and found that this was satisfactory. Medication administration records were correctly completed following the administration of any medication. Records of the daily room and fridge temperatures had been maintained. This showed that medicines were stored at the correct temperature to ensure they worked effectively.

There was insufficient analysis of accidents and incidents to monitor trends to try to prevent future accidents and incidents. There was inconsistency of how the incidents were reported. Some incidents were reported in an accident book and others were recorded on accident and incident forms. Where incident forms were completed, there was not always information on what actions had been taken to reduce further risks. For example, one person had a number of aggressive outbursts. There was no additional information on what actions were taken as a result.

We reviewed four people's care files and found individual risks had been identified, including mobility, falls, nutrition and the use of bed rails. However, one person who displayed behaviours that could challenge, with the potential to cause harm to others, had very limited guidance recorded into their care plan and risk assessments. There was no information about what might trigger this person to be aggressive. This meant staff were not fully aware of the risks this person could pose to themselves or others, or how to mitigate those risks. We asked the provider to update this person's behavioural risk assessment during the inspection, to add further detailed information on how the staff team needed to support safely support this person.

During our inspection we completed an observational walk-about of the home to establish who was being cared for in their bedrooms. We were introduced to one person who had just left their bedroom and we were told by a staff member this person was 'difficult'. We found the care staff on duty did not fully consider this person's impairments and perceived the person as "difficult", instead of respecting that their care needs were increasing.

Failure to safely mange risks to people and the poor management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had infection control systems in place. These included regular cleaning of the premises and equipment. Protective Personal Equipment (PPE), such as disposable gloves and aprons, was available for staff to use when supporting people with personal care.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was working within the principles of MCA. DoLS applications had been made to the local authority and some were awaiting approval. This helped to ensure people were not being unlawfully restricted.

We viewed the providers DoLS tracker which detailed people's DoLS status and applications to the local authority. However, we found the DoLS tracker had not always been updated when there was a change, such as a DoLS renewal. We spent time looking at people's DoLS applications and were generally satisfied the appropriate DoLS were being applied. However, we found one person who had been at the service since July 2015 had not yet received a mental capacity assessment by the provider, even though the staff team felt the person lacked mental capacity to make certain decisions, such as leaving the home independently. We found no DoLS application had been made for this person. During the inspection the provider confirmed this would be addressed. However, we were concerned that the provider and manager did not currently possess the appropriate skills to undertake capacity assessments.

We found a further instance when the MCA 2005 was not followed for one person. We found assistive technology had been introduced during the night that would alert staff when this person got out of their bed. The aim of this technology was to reduce falls. We found this person was deemed to lack a mental capacity and a DoLS had been applied for. However, we found no discussion or best interest meeting had taken place to confirm whether the assistive technology was in this person's best interest. This also meant to provider was not following their own policy 'Informed decision making'. This policy stated the following, "It is vital that managers and staff are able to describe the evidence drawn upon and the critical thinking that had led to the reason for making the decision. This information should be able to be satisfactorily demonstrated to all stakeholders involved."

Although we noted on the providers training matrix the majority of care staff had received training in relation to the MCA, the staff we spoke to during the inspection were unable to tell us about the MCA and how it applied to the people they supported. One staff member told us, "I know we have DoLS for some people, but no idea what for." Another staff member told us, "We don't tend to know about the DoLS, this is the manager's job." The impact of this was significant because many of the people in the home were living with dementia. The staff team supported a number of people with complex needs relating to their dementia, who would be subject to a number of restrictions to keep them safe. We did observe instances where staff asked people's consent before providing care. This showed consideration to people's right to consent to day to

day decisions. However, the provider did not have effective systems in place to ensure people's legal rights were maintained.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain good health. However, we found inconsistencies with the approach care staff and the provider took when people lost weight.

For example, we noted from one person's weight charts that they had been gradually losing weight every month. We did not see evidence that confirmed this person had been seen by their GP to discuss their weight loss. This person also had a Malnutrition Universal Screening Tool (MUST) in place, however we found this had not always been completed correctly, as the graph on the MUST had not been fully populated to consider the person's body mass index (BMI) score. A 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. Shortly after the inspection we received the providers action plan that detailed all staff would receive training on how to correctly complete a MUST. We will review the progress of this at our next inspection.

We noted a similar recurrence for a second person. Although we could see in June 2018 that their weight loss had been escalated to the appropriate medical professionals, we were not satisfied their recommendations had been followed by the home. This person had a specific dietetic care plan in situ implemented in June 2018. A number of key recommendations were put in place to support this person to increase their weight. We found the recommendation of being weighed weekly was not being followed by the home. This person was last weighed in September 2018, this meant the provider could not be assured if this person was continuing to lose weight and whether timely medical interventions needed to be introduced. This person also had a MUST in place. Again, the accuracy of the recordings meant information recorded on the MUST was not relevant due to care staff not completing this fully. During the inspection we raised two safeguarding referrals and the provider made two urgent GP appointments for both people.

This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records of training and saw training had been provided in areas including safeguarding adults, moving and handling, infection control, fire safety, food hygiene, health and safety, first aid and dementia awareness. We found a number of these courses had been completed by the majority of the staff team. However, as we have already mentioned in the safe key question of this report we found staff had never been provided with training in challenging behaviour awareness or breakaway. We noted an incident during the inspection where we observed how staff dealt with a challenging incident and judged this had not been managed by staff with confidence. We discussed this area with the provider who confirmed they would be seeking training for all staff in this area. We will review this at our next inspection.

New staff had been recruited and employed to work at the service since the last inspection. The new staff had not yet completed an induction which was based on the Care Certificate, however we noted these staff members already had a QCF level 2. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. We were informed by the manager they would soon be enrolled on this induction.

Staff had regular supervision and appraisals. Staff confirmed that they had the opportunity to meet with the manager or senior care staff on a regular basis. We saw from the records that the previous manager had a

matrix in place to ensure that supervisions were undertaken regularly.

Everyone in the home at the time of our inspection had received a pre-admission assessment to ascertain whether their needs could be met. This had been done wherever the person was; this included their own home and other care settings such as respite centres or hospital. We looked at the pre-admission paperwork for people currently living in the home and could see that the assessments had been completed.

Requires Improvement

Is the service caring?

Our findings

We asked the provider and manager how people's privacy was maintained in view of the use of CCTV in communal areas, which monitored and recorded people's actions and conversations. We asked the provider why they felt this was necessary. They said it was, so they could 'check back on things'. We also asked the provider whether or not people, or their lawful representatives, had been consulted before the CCTV had been installed and we were told they had been. However, we found no supporting documentation confirming this.

During the inspection we spoke to two family members who told us they were aware of the CCTV in the home, but told us the use of the CCTV had never been explained to them. A further point in the policy included, "The use of cameras is transparent, and all service users, staff and visitors should be made aware that a CCTV system is in operation. The manager should ensure internal and external signs are displayed informing people that there is a CCTV system in operation." Throughout our tour of the home we found no signage available to inform people CCTV was in operation.

When surveillance is used for any purpose, providers must make sure this is in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. We found the provider had not fully considered this and ensured the use of CCTV systems were operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website.

This demonstrated that people's rights to privacy and dignity were not maintained at the home. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to dignity and respect.

People we spoke to could not recall whether they had been involved in planning their care needs. However, care records contained some personalised information which showed that people had been involved to some extent. For example, personal preferences around favourite foods were available, and in some instances information about preferred activities was recorded. The two people's family members we spoke with confirmed that they had never seen their relative's care records or been involved in the planning of their care. In situations where people do not have capacity to make decisions regarding their care needs and have a legally appointed deputy, it is important that this person is involved.

Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them. Through talking to staff and members of the management team, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected.

People were supported to be independent where possible. One staff member told us, "We know it's important to allow people to do as much as they can for themselves." We observed one person being assisted to gather food on their fork during lunch. The staff member assisting them allowed them to eat the contents of the fork independently as they were able to without assistance. People were supported to

communicate in ways that suited their own individual needs.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed there were no restrictions when they visited, and they were always made to feel welcome. Throughout the inspection, we observed numerous examples of positive and caring interactions between staff and people who used the service. However, opportunities for such interactions were limited as staff primarily focused on the delivery of task-based care.

Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them. Through talking to staff and members of the management team, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality. Although the service did not discriminate against people, to fully embed the principles of equality, diversity and human rights, we recommend the service consults the CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.'

Requires Improvement

Is the service responsive?

Our findings

We reviewed four care files and saw they contained a range of information, including personal and social details, care plans and risk assessments. Risk assessments we viewed included those for falls, diabetes, pressure sores and epilepsy. We found the care plans were not easy to navigate and held a number of outdated records that were no longer relevant. Furthermore, we found the care plans folders were being stored in an unlocked cupboard in the dining room. For confidentiality purposes we explained to the manager this cupboard needed to be locked. They confirmed they would address this matter.

Incident records showed one person was repeatedly anxious, and could display behaviours that were challenging, sometimes at specific times, such as when they were in the lounge. Staff completed incident forms which were intended to identify any triggers to behaviours that challenged, what the behaviour was and what staff did to manage the situation. For this person, we saw their incident forms recorded 'reassurance given to no effect' had been recorded on separate occasions in the month before our inspection. The person's care plan listed just two strategies to help care be provided without triggering any behaviour that challenged. This included to offer reassurance and give the person their personal space. The incident forms did not demonstrate what aspects of the care plan had been followed and which strategies had or had not worked. Whilst we saw a referral had been made the following month to external health professionals and some potential health causes had been considered as contributing factors; there was no analysis of what strategies in the person's care plan were not working. As such, we were not assured this person had always received responsive and personalised care.

People's comments about social activities provided were variable. One person told us, "I am stuck in here, I don't go anywhere." Another person told us, "I think the activities could be better, even if some entertainers popped in every now and then." Staff confirmed improvements were required to ensure people using the service had their social care needs met, but stated they did not have the time to provide this.

We observed that for the majority of the day most people were sat for long periods of time with no stimulation and were disengaged with their surroundings. Most people spent their day in the main lounge with the television on and the volume very low. Staff were seen to be available in the lounge area, but did not take the initiative to ask people if they would like to take part in an activity other than watching the television.

We discussed the activities on offer with the manager and provider who both commented that the activities were being reviewed and they were fully aware further improvements were needed in respect of planning activities and ensuring they were person centred to people's interests. We will continue to monitor the progress of this.

The provider failed to ensure that people received a service that was centred on them and that met their needs, preferences and provided social stimulation.

This is a breach of Regulation 9 of the Health and Social Care act 2008 (Regulated Activities) Regulations

2014.

We asked the manager what actions they had taken to meet the accessible information standard. From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS). Services must identify record, flag, share and meet people's information and communication needs. The manager told us they were not familiar with this standard. However, they told us if people required information in large print for example, this could be arranged for them. Whilst we saw care plans were in place for people's communication needs, we did not see how this had been extended to assess what format people might require information in. For example, information such as the complaints procedure and their care plan in order to facilitate their involvement in it.

People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the provider or manager, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy.

We reviewed the home's approach to end of life care (EoLC) and we were told that in such circumstances, community EoLC professionals such Macmillan Specialist Nurses were usually involved, in addition to a person's own GP. People who received care towards the end of their life had care plans in place. We saw these detailed any anticipatory medicines that may be required for pain relief. People's wishes, such as whether they wished any family members to be present were also recorded.

Inadequate

Is the service well-led?

Our findings

During the inspection we found a number of concerns about the service. We raised these with both the manager and the provider and following the inspection we requested that urgent action was taken to mitigate the immediate concerns.

The registered provider submitted an action plan that told us that remedial work was being undertaken, which reassured the Commission the risk had was being managed. We referred the findings from this inspection to the local authority, Manchester City Council, who shortly after the inspection, temporarily suspended new admissions to the home and undertook a number of quality assurance visits at the home.

At the time of this inspection there was a manager, however they had not yet registered. 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 had been notified that the previous registered manager had left in November 2018. The service has had several management changes over the previous two years, which the provider agreed has not helped continuity for the home. Shortly after our inspection the provider contacted us to say they had dismissed the manager.

People and staff told us the management of the service was not good. Comments received from the people at the home included, "I haven't got a clue who this new manager is. She hasn't even said hello" and "It's the staff running this place." Comments received from the care staff were also of a negative nature, "The new manager just sits in her office all day, what's the point?," "I have only spoken to the manager once, not sure if she will stick around" and "The manager has brought in a number of her own staff. I know for a fact they don't have a DBS in place. What does that say about the manager?"

During the inspection we viewed the new manager's recruitment file. We found this manager had been recruited to the home without a DBS check in place. Furthermore, we found evidence that one of the manager's references was completed by their family member, but the reference did not disclose this. Shortly after the inspection the provider made the decision and dismissed the manager, along with four care workers who did not have the appropriate DBS checks in place. Since the inspection the provider has engaged with a health and social care consultancy company to assist them with making the necessary improvements at the home.

Throughout the inspection visit we identified examples of poor practice amongst staff that demonstrated there was not a person-centred culture within the service. Staff lacked daily co-ordination and were under managed. For example, we found staff were taking their breaks together at the same time. This led to shortages of staff at specific times. Furthermore, we were concerned with the approach of one member of staff who at times showed a poor attitude to the inspectors. For example, while working in the lounge this staff member repeatedly banged care plans and records on the table the inspector was using to view records.

Before the inspection we had received concerns from a member of the public and two whistleblowers. The concerns raised were about the culture amongst staff, as well as the poor quality of care that people received. Two members of staff told us that they felt unsupported by management and we concluded from the inspection findings that there was a lack of leadership and management support in the service.

There was a lack of provider oversight and governance at the service which impacted negatively on the care that people received. We asked for clarity from the manager around roles and responsibilities of the registered provider but did not get any assurances that there were clear lines of accountability within the management team. During the two days we inspected it was clear from a number of shortfalls identified at this inspection that the registered provider had no oversight or governance of the service.

There were no audit systems being completed in relation to falls, weight loss, pressure wounds, care plans or the environment. The manager told us that whilst information in relation to these areas was being collated, no analysis of this information was taking place to identify trends or patterns. We identified issues with the information contained within care records. This was not always up-to-date and meant that the service had little assurance that people were receiving the support they needed. We also identified hazards relating to the environment which had remained unaddressed at the time of the inspection visit. For example, there had been no examination of the passenger lift or risk assessments. This placed people's health and safety at risk. The manager and provider told us that audits would be implemented and took immediate action to address specific concerns we had raised.

Quality assurance procedures did not effectively assess, monitor and mitigate risks to people including their health, safety and welfare. For example, where accidents and incidents were being recorded, no analysis had been undertaken to identify themes and recurring trends thereby limiting future occurrences. We found where quality assurance systems were in place they were ineffective. The provider had failed to both identify the issues we found during the inspection and to ensure that the service was compliant with the Health and Social Care Act 2008.

We saw a number of surveys and questionnaires were completed by people with an interest in the service. These included resident's surveys and surveys for professionals. We found the surveys were not analysed and action plans were not developed from them. Surveys are a tool for improvement and should be used as such. If actions are not identified from the feedback provided, then the feedback has not served its purpose.

The lack of clarity around the individual roles and responsibilities of the management team and the resulting lack of accountability meant the home was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The quality and safety of services provided were not assessed or monitored in order to identify any required improvements.

It is a legal requirement that regulated services are operated and managed in an open and transparent way. As we have outlined in this report, the registered persons at Lindenwood Residential Care Home failed in this regard. In particular, there were systemic failures to inform relatives and/or lawful representatives when significant allegations of a safeguarding nature were made; a failure to notify relevant persons, such as the local authority and CQC.

This was a breach of Regulation 20(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to duty of candour.

The registered provider is required by law to notify the CQC of specific events that have occurred within the service. As already mentioned in the safe key question of this report we found two significant safeguarding

concerns and neither had been notified to the local authority or CQC. This meant that the registered provider was not complying with the law.
This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, because the registered provider had failed to notify where required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people received a service that was centred on them and that met their needs, preferences and provided social stimulation.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people received a service that was centred on them and that met their needs, preferences and provided social stimulation.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that people received a service that was centred on them and that met their needs, preferences and provided social stimulation.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicine was not always safe which put people at risk. We found inconsistencies in respect of recording keeping and we found

people did not always have detailed guidance in place for 'when required' medicines.

And

There was insufficient analysis of accidents and incidents to monitor trends to try to prevent future accidents and incidents.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We were not assured that systems and process for safeguarding people who used the service from abuse were operated effectively.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were supported to maintain good health. However, we found inconsistencies with the approach care staff and the provider took when people lost weight.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not taken reasonable practicable steps to mitigate risks to the health and safety of service users.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not taken reasonable

	practicable steps to mitigate risks to the health and safety of service users.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not taken reasonable practicable steps to mitigate risks to the health and safety of service users.

The enforcement action we took:

We served a Notice of Proposal to cancel the registered providers registration