Guild Care

Linfield House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 29 September 2015 and was unannounced.

Linfield House is a purpose-built home that provides nursing and personal care for up to 54 people with a variety of health and care needs, including people living with dementia. The home is divided into five units: Richmond unit caters for people living with dementia and is a secure unit. The other four units provide nursing or residential care: Whitcomb, Frazer, Selden and Gordon. People living in the Richmond unit have separate facilities comprising a sitting room, dining room and have access to a garden. The other units are housed on the 1st and 2nd floors at Linfield House. Each suite of two units has its own small lounge, kitchenette area and bathroom. There is a communal lounge and large dining room on the ground floor and a further dining room on the first floor. All rooms have en-suite facilities, including a shower. There are accessible gardens at the rear of the property which overlooks Victoria Park. The home is situated close to the centre of Worthing.

There was no registered manager in post at the time of our inspection, but the person currently managing the home was in the process of registering with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Staffing levels had not been assessed based on people's care needs. Staff were busy trying to support people safely, but there were not always enough to do so at the time of our inspection. There were insufficient staff to support people at lunchtime and some people had to wait a long time for assistance. Call bells were not always responded to promptly. People felt safe living at Linfield House and staff had been trained to recognise what might constitute potential abuse and what action they should take. Risks to people were identified and assessed appropriately and risk assessments were reviewed monthly. There was information and guidance for staff on how to manage people's needs safely. The service followed safe recruitment practices. Generally, people's medicines were managed safely. However, there were two instances on the day of inspection when staff left the medicines trolley unlocked when administering medicines. The home was generally clean and hygienic.

There was a mixed response from relatives regarding whether all staff had the knowledge and skills they needed to care for people effectively. New staff underwent an induction programme and progressed to the Care Certificate, a universally recognised qualification. Staff completed all essential training and received regular supervision and annual appraisals from their supervisors. People's consent was gained in line with current legislation under the Mental Capacity Act (MCA) 2005 and associated legislation under the Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of this legislation and put what they had learned into practice. Generally people had sufficient to eat, drink and maintain a balanced diet. However, a shortage of staff at lunchtime meant that some people were not supported adequately. The lunchtime experience in Richmond unit was in contrast to that of people in the main dining room. People in Richmond were supported effectively and encouraged to eat their meals. People were supported to maintain good health and had access to healthcare professionals as needed.

Mostly people were looked after by kind and caring staff. There were occasions, however, when people were not always responded to by some staff when needed and were ignored. Other staff were patient, warm and friendly with people and were receptive to their needs. People and their relatives were not always involved in discussions or decisions about their care, with the exception of their end of life care. Mainly, people were treated with dignity and respect.

Care plans provided staff with detailed, comprehensive information about people and how they wished to be cared for. Care plans were reviewed monthly. Some relatives felt that people's care was managed well, whilst others felt this had taken time to achieve. Relatives could visit at any time and were made to feel welcome. There were some organised activities for people at Linfield House, however, these were not always meaningful for all the participants. Some outings were available to people, but generally there was little opportunity for people to go out of Linfield House, unless they were supported by their relatives or friends. Complaints were listened to, acted upon and dealt with to the satisfaction of the complainant.

People felt the home was well run and that the management were approachable. Some staff felt that, whilst the manager was amenable, she was not always available to observe what was happening in all parts of the home. People's personal information was not always kept confidentially, but left in folders in open offices. Audit systems were in place but did not always identify and assess improvements that were required.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were not safe.

Staffing levels were insufficient and had not been assessed based on people's needs.

People received their medicines as prescribed, but some staff did not always keep medicines securely in the trolley during the medicines round.

People felt safe and free from harm and staff had been trained to recognise the signs of potential abuse and knew what action to take.

The home was clean and hygienic and people were protected from the risk of infection.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

People thought the food was good, but the lack of staff left some people waiting a long time in the dining room between courses or when they had finished eating.

Staff received training and supervision but not all relatives considered some staff had the knowledge to care for people effectively.

The requirements of the Mental Capacity Act (MCA) 2005 and associated legislation under Deprivation of Liberty Safeguards (DoLS) was understood by staff and put into practice.

People were supported to maintain good health and had access to healthcare professionals.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

People felt that staff were kind and caring. However, there were occasions when staff were not supportive of people. Call bells were not always responded to by staff promptly and people's cries for help were sometimes ignored.

Some people and their relatives were not always involved in discussions about their care.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

Care plans contained detailed, personalised information about people and were reviewed monthly by staff.

Summary of findings

Relatives could visit at any time and made to feel welcome.

There were some organised activities for people to participate in at the home.

Complaints were dealt with promptly and to the satisfaction of the complainant.

Is the service well-led?

Some aspects of the service were not well led.

People felt the service was managed well and could participate in residents' meetings. However, action points arising from these meetings were not recorded.

People's personal information was not kept securely, but left in an open office in some of the units.

There was a range of audit systems in place, but these did not always accurately identify areas for improvement.

Requires improvement

Linfield House

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 29 September 2015 and was unannounced. Three inspectors and an expert by experience in dementia care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, six staff files which included recruitment, induction and training records, supervision and appraisal records for seven staff, staffing rotas, 10 Medication Administration Records (MAR), complaints and other records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day of our inspection, we met and spoke with nine people living at the service and six relatives. We spoke with the manager, the deputy manager, the head of nursing and quality, a registered nurse and five care staff.

The service was last inspected in November 2013 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

Staffing levels had not been assessed or monitored to ensure they were sufficient to meet people's needs. The manager said that staffing levels remained consistent and that there were always the same number of care staff and nurses on duty in each unit, regardless of people's individual care needs. People's needs were not formally assessed to calculate the number of staff needed. They added that they did not employ a dependency tool to look at the ratio of care staff to people and people's dependency levels. Therefore they could not be sure that the number of staff deployed was sufficient to safely meet people's needs. At the time of our inspection, 23 people had nursing needs. Overall, on the morning shift, there were two registered nurses and 12 care staff delivering care for people who lived at the service in five separate units. Except for the Richmond unit, which had a higher level of staff, each unit only had two care staff to care for up to 13 people. If one person needed the support of two staff, for example, to assist in safe moving and handling, then there was no additional staff left to support other people in the unit, except for the registered nurse who had to cover two units.

We looked at the staff duty rota for the previous four weeks and asked the manager how staffing levels were decided. The rota revealed staffing levels were consistent across the time examined, with three care staff plus a senior carer in the Richmond unit and two care staff in each of the other four units. The provider used existing staff where possible to cover vacant shifts left by sickness or annual leave and used bank staff to fill any gaps.

One person, who also had a family member living at the home, told us, "[Named person] doesn't have a call bell; that spoils it for me, it's not asking a lot. There's no contact for help and as you get older you get weaker and all [named person] can do is shout. I keep on about it, it's not satisfactory, it's vital. The chap next door has one. If I could, I'd buy one myself". We asked one of the managers about this and they told us that the person in question would have been unable to operate a call bell, therefore, this had not been made available. The person who told us of their concerns felt that their family member could have summoned help if they had been given a call bell and that staff did not check on them regularly enough to ensure their safety.

At 11.30am, in one of the units, we asked to talk with a member of care staff. They told us that they could not accede to our request as they were, "Too busy" and informed us that they had yet to get four people up and dressed before lunch was to be served at 12.30pm. Our observations confirmed that this was the case. One person said, "I wake up early and I just have to wait. It can be half an hour before anyone comes and then another half an hour before I get breakfast. They give me breakfast in bed, but I would rather be up, washed and dressed and in my chair and I should like a shower more often". Another person felt that call bells were not always answered quickly by staff. We observed one bell had been rung in Frazer unit at 11.59am and was not responded to by staff until 12.07pm. However, staff responses to call bells varied from unit to unit, with some being answered fairly promptly and others with a time delay. Therefore people requiring assistance did not consistently receive a timely response from staff.

During lunch, we observed that 21 people were eating their lunch in the main dining room on the ground floor. One person was in a wheelchair and required 1:1 support to eat. Initially, they were provided with this support by staff, but later on, staff were too busy to continue supporting this person and we observed they had fallen asleep. There were only two care staff on duty at one point to serve meals, collect plates and provide support. This meant that people who required support had to wait and staff did not have time to chat with people as they were too busy running between tables. Some people had to wait a while to have their plates cleared away before the dessert was offered.

Another person said, "I don't like there always being new staff. They're all younger ones now and they never have time to stop and talk to you, whereas the older ones used to". A relative said, "I would have thought consistency would have been crucial, but there can be lots of unfamiliar faces and it's more noticeable at weekends".

On the day of our inspection, a person was being admitted to the home and was shown their room. A member of care staff, the manager, deputy manager and a registered nurse spent time with the person and their family. Two people in wheelchairs were left alone from 11.50am until 12.16pm at which time a member of care staff went to get something and just said "hello" in passing. During this time, there was no interaction or input from staff and no staff were available during this time in the unit.

Requires improvement

Is the service safe?

We asked staff members the question, "Do you think there are enough staff on duty to consistently care for people safely?" One care staff said, "No, there aren't. People [referring to staff] are leaving because of it. It's a shame because we're such a good team. We sometimes say we'd be better all working together for someone else". Another staff member said, "We are run ragged most of the time, it's not fair. The management know about this, but nothing happens". A third member of staff said, "It's okay in Richmond because they have more staff. In the rest of the place, it's always short".

Staffing levels were not reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.

This shows that there were insufficient levels of staffing to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they felt safe at Linfield House and that they were free from harm. They said they would speak with staff if they were worried or unhappy about anything; this included their possessions being kept safely. One person said, "I'd speak to one of the nurses or even a carer if I was worried about anything". Another person told us, "I feel safe here and, oh yes, I'd say if not". A relative said, "I wish I'd moved [named family member] here sooner. It's the first time in four years I've been away on holiday and not worried about their care and how they're being looked after". Another relative confirmed they had no concerns about the safety of people living at the home. They told us, "I don't really think about it. I think the staff are very caring".

Staff members confirmed they had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse was taking place. Staff were aware that a referral to an agency, such as the local safeguarding authority, should be made, in line with the provider's policy. One staff member explained, "I would definitely tell my manager if I saw or heard abuse going on". Another member of staff said, "I would go higher than the manager and go outside the organisation if I had to". One member of staff was not clear on what constituted abuse or how to report it. They said that abuse was not giving people choice, how you speak to them, manual handling, rolling people over and fragile skin. They said they would probably report abuse to the registered nurse or the management. Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

Risks to people and the service were managed so that people were protected. People's risks had been identified and assessed and there was information in their care plans to guide staff on how to mitigate the risk. Risk assessments had been drawn up in a range of areas, such as diet, skin integrity, falls and the compilation of personal emergency evacuation plans. Risk assessments were reviewed monthly. When people had sustained a fall, their risk assessment was reviewed straight away and action taken. For example, where one person had suffered more than one fall in a month, a referral was made to the local authority's falls team for advice and support. Accidents and incidents were recorded appropriately by staff, monitored by the manager and action taken as needed. There were arrangements in place for the management of pressure ulcers. One person had a grade 2 pressure ulcer. The registered nurse told us, "We do the dressings and they're on an air mattress". She went on to explain that people with pressure ulcers would be seen by the GP and, if necessary, the GP would make a referral to a tissue viability nurse.

The service followed safe recruitment practices. Appropriate checks were undertaken before staff began work. Staff files contained recruitment information and criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant that checks had taken place to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documents, including character references and job descriptions in staff files.

People's medicines were generally managed so that they received them safely. Relatives said they felt that medicines were administered on time and that there were sufficient stocks of medicine kept, so that people did not run out. One relative said, "They seem to take care of all that for [named family member]; there's never any problems". Another relative told us, "Yes, [named family member] is on antibiotics just now. They rang me to tell me that they'd arrived and that [named family member] was starting on them today".

We spoke with staff about medicines management. We asked how medicines were acquired, dispensed and

Requires improvement

Is the service safe?

disposed of. We examined the Medication Administration Records (MAR) for 13 people. We also observed the dispensing of medicines by registered nurses and looked at the provider's medicines' management policy. One staff member did not follow guidance from the Royal Pharmaceutical Society. We observed during the lunchtime medicines round that on two occasions the medicine trolley was left open and unsupervised whilst they gave people their medicines and on another occasion the medicines trolley was left unattended in the corridor outside one person's room, while they were administering their medicines. This left medicines at risk of theft or misuse. We brought this to the attention of the manager when we gave feedback at the end of the inspection. They said that this would be addressed with the staff in question and staff would be reminded of the importance of not leaving the medicines trolley unattended.

Staff had signed each entry in the MAR to show that people had received their medicine as prescribed. All medicines were delivered and disposed of by a pharmacy. Medicines were managed in line with the provider's policy. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medicines were safely stored in locked trolleys. Medicines requiring refrigeration were stored in a lockable refrigerator dedicated for that purpose. The temperature of the fridge and the room which housed it was monitored twice daily to ensure the efficacy of the medicines. Controlled drugs were stored separately in a locked cabinet. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated regulations. The documents relating to the obtaining and dispensing of controlled drugs was kept accurately. Two staff had signed the controlled drugs register when a controlled drug was administered, in line with current legislation. Medicines given on an 'as required' (PRN) basis were managed appropriately and staff understood the purpose of the medicines they were administering. A registered nurse told us, "We have homely remedies and the GP has signed for them all", indicating that people could take these remedies safely and that the effect on their regular medicines would not be compromised.

No-one at the home managed their own medicines. One person received their medicine covertly, that is, without their knowledge. The documentation related to this showed that the home had sought appropriate guidance in line with current legislation. The person's mental capacity had been assessed and a 'best interests' meeting had been held between the home, the person's family and health professionals to decide the best and least restrictive course of action.

The home was clean and hygienic and generally people were protected against the risk of infection. Comments from people and their relatives were, "They're always cleaning, it's non-stop", "There's never any smells here, unlike lots of other places we visited before" and "Yes, you'll see they always use the gloves and plastic aprons when they should". A laundry on the ground floor serviced the needs of all the units at the home. However, we observed that cleaning staff did not routinely wear aprons and they used the same pair of gloves for all laundry handling in the rooms, so there was a risk of cross-infection. This was pointed out to the manager, who said they would speak to the staff concerned.

Requires improvement

Is the service effective?

Our findings

People generally received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. However, there was a mixed response from people and their relatives about the competency of some staff. One relative told us, "Yes, I can see a big difference between this place and the last place [named family member] was at, where they just didn't know what they were doing". Another relative reported, "It has been a really stressful time. [Named relative] has been here a few months now and I think it's been a learning curve for them [staff]. We have been shocked as we thought they would know what they're doing, but I don't think they've had anyone like [named family member] before". The relative thought that staff had little understanding of the health condition their family member had. They explained, "To look at [named family member] you'd think she was all right, but we've had to keep telling them about things like brushing teeth, washing hands and having a shower".

New staff underwent a formal induction period. Staff records showed this process was structured around allowing staff to familiarise themselves with the provider's policies, protocols and working practices. We spoke with staff about the induction process. One staff member said, "It was okay, but it was very busy at the time, so it was just about getting on with it". Another staff member told us, "I didn't get an induction at all. I was just asked to work two 12 hour shifts and that was it. I'm lucky in that I wasn't new to care". All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics, which the provider had introduced.

Staff files contained information on staff training and all staff were able to access training in subjects relevant to the care needs of the people they were supporting. Some staff had achieved qualifications such as a National Vocational Qualification (NVQ), Level 2 in Health and Social Care. Training was provided in infection control, health and safety, moving and handling, fire awareness, safeguarding vulnerable adults, first aid and the care of people with dementia. Other training undertaken by staff included communicating effectively, getting to know Guild Care and managing challenging behaviours. Staff were satisfied with the training opportunities on offer. One staff member said, "The training there is good, but we're short staffed, so you feel bad sometimes going on training". Another staff member told us, "I think we have enough training to do our jobs".

We looked at seven supervision and appraisal records and asked how staff were formally supervised and appraised by the provider. Supervision sessions and yearly staff appraisals for staff had been undertaken or was planned, in line with the provider's policy. The staff we spoke with were happy with the supervision and appraisal process. One staff member said, "It's okay, but I'm not sure whether the things we say we want to improve ever really get heard". Another staff member told us, "I'm not a person who holds back, so I wouldn't wait for supervision. I'm not sure it makes much difference though". Staff meetings were held with general staff meetings taking place at least every quarter. Separate staff meetings were organised for nursing staff, domestic staff and night staff. Records from a nursing staff meeting held in September showed a range of topics had been discussed: core risk assessments, monthly review of residents, resident of the day, supervision and appraisals. This meant that people received effective care and treatment from staff who received regular supervisions and feedback from their supervisors.

The provider offered training on the Mental Capacity Act (MCA) 2005, including Deprivation of Liberty Safeguards (DoLS) as part of dementia training. Staff had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff could tell us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. DoLS is part of the Mental Capacity Act. The purpose of DoLS is to ensure that someone is only deprived of their liberty in a safe and appropriate way. This involves an application to the local authority for a DoLS authorisation. These are granted if someone lacks capacity to consent to their care and treatment and their liberty restricted for their own safety. People's capacity to consent to care and treatment had been assessed and records in care plans confirmed this. The management had completed 35 applications for DoLS which were acknowledged as being received by the local authority. However, none had yet been authorised by the local authority which was out of the provider's control. One staff member told us, "I think the most important thing is that people can make decisions for themselves unless it's

Is the service effective?

proven otherwise". Another staff member told us, "I know about best interests meetings. We can't just make decisions about people without making sure it's right for them".

Generally, people were supported to have sufficient to eat, drink and maintain a balanced diet. An outside catering company supplied meals, but all food was cooked on site. The main meal was served at lunchtime and many people chose to eat in the main dining room located on the ground floor. We were told that relatives could also join their family members for meals if they let staff know. One person said that the, "Food was excellent and we're well looked after". Another person was not aware of the menu on the day we inspected, nor did they think they had a choice of food. We asked a member of care staff what was on the menu that day, but they did not know either. Menus were not available at any of the units, so people did not know what was on offer until they were presented with the meal. In the main dining room, the majority of people were given fish in batter, vegetable and mashed potato. Although there was an alternative choice on offer of beef hotpot, people did not appear to be aware of this. Therefore people had not been enabled to make choices about their diet.

Staff were rushed and intent on ensuring that people received their meals, rather than having time to chat. However, staff, as much as they were able, were attentive throughout the meal and offered people more drinks. We observed that one person had a drink of blackcurrant and another drink in a spouted container. It was not clear why the additional drink was in a spouted container as the person demonstrated they could drink the blackcurrant perfectly well from the glass. People were not encouraged to eat more even if they had left most of the meal. Care staff just asked if they had had enough and then took the plates away. No-one was asked if they would like second helpings of food. One member of care staff was seen to move one person's dining chair, whilst the person was sitting in it. However, the dining chair was a normal chair and not one that should be used to move people safely in this way.

Lunch was served separately for people living in the Richmond unit. The presentation of the dining area in this unit was in contrast to the main dining area, which was attractively laid out. In the Richmond unit there were bare tables with only placemats in situ. However, people were guided and supported sensitively to the dining area and were asked where they would like to sit. Some people chose to stay in the lounge area and eat from an individual table. People who needed support with their meal were assisted by care staff. One person was supported to eat their meal in bed. The pureed meal that they were eating had been nicely presented with the different food groups divided into separate sections. Risks associated with people's risk of choking or swallowing had been assessed appropriately and advice sought from a speech and language therapist. Some choices were offered to people, for example, where they wanted to sit, any accompanying sauces, whether they wanted more to eat and a choice of a hot or cold drink.

Lunch was served in a very calm manner in the Richmond unit and staff sat with people at the dining tables to eat with them. This created an opportunity for shared jokes, laughter and conversations. Staff knew people well and made reference to this. For example, "There's pasta today from Italy, where your lovely husband is from". People thought the food was good and that they had enough to eat. One person said, "The food's pretty good and you get a good choice". Another person told us, "I'm very happy with the meals". There were three choices of menu offered on the day we inspected and people could have a look at the food before being served. However, we did not see any menus for people to look at nor any pictorial material to support people living with dementia to make choices.

In people's rooms, we observed there were lots of unfinished cold drinks, although people said they always had a drink to hand apart from one person. This person had a cup of tea earlier, but sat separately in the lounge and did not have a drink on their table. In another unit after lunch, whilst there were full jugs of juice on the sideboard, no-one had a drink or was offered a drink, until the afternoon drinks were brought round. Therefore people may not have been given opportunities to drink sufficiently throughout the day.

Where people were at risk of malnutrition or dehydration, food and fluid charts were kept to record the quantities that people had consumed. People's weights were recorded and monitored monthly and care records confirmed this. A registered nurse told us, "If they're losing weight, we will refer to the GP".

People were supported to maintain good health and had access to healthcare services and professionals. Some people preferred to keep their own GP when they came to

Requires improvement

Is the service effective?

live at Linfield House, otherwise people saw health professionals from a local surgery. A GP visited the home every Wednesday. One person told us, "I've stayed with my own doctor. A lot of them here see the doctor that covers this home, but I wanted to stay with my own, so I see people that know me". People felt that medical attention would be sought promptly if needed. One relative said, "[Named family member] can be prone to urinary tract infections and they get straight onto it, to get antibiotics when it's needed". However, another relative had been annoyed as a member of care staff was needed to help them support their family member to a hospital appointment. The relative had to insist that this happened as they were clear they could not manage alone and needed support. They told us, "I don't think the deputy was very happy with me, but what would have happened if I wasn't here?" Other comments from people included, "I've got new hearing aids, they've made such a difference" and "I think the optician is coming in next week or the week after, so we'll be seen then here at the home".

Whilst the building and garden areas at Linfield House were safely accessible to people, this relied on people using the lift, as other areas were locked to protect the safety of some people. One person said, "I can't even go out to the shops. It's the only thing I complain about, they've got us all tabulated. I can go with a relative, but I feel like a prisoner".

We were told that people could go out into the garden, although we did not see this on the day of our inspection, even though the weather was quite warm. Linfield House is a purpose-built care home and attention had been paid to the use of colour contrasting carpets and furnishings, to aid people as they moved around the home. In the Richmond unit, people had memory boxes outside their rooms which contained photos or items of interest that were important to them. Where relatives supported family members, rooms contained personal memorabilia and photos, but other rooms were stark and unhomely.

In the Richmond unit, one room had been set up as an old-fashioned tea room and furnished with a dresser and a piano. However, we did not see anyone use the room on the day we inspected and some staff appeared to take their tea breaks in there. Therefore the room may not have been utilised to its full potential as a reminiscence space. The main sitting room area offered people living with dementia opportunities to reminisce or look after a doll in a pram. There was gentle music playing, a date and weatherboard, a large clock, soft toys, rummage boxes and a fire place. There were grandfather clocks in various areas of the home, but none appeared to be working and the time shown was incorrect. This would have been confusing for people living with dementia.

Requires improvement

Is the service caring?

Our findings

Generally people were treated with kindness and compassion and were looked after by caring, warm and friendly staff. However, we observed instances on the day of our inspection which were less caring.

We sat in on a handover meeting in the Selden unit and the registered nurse was sharing information with care staff. During the meeting, we heard one person calling out for help saying, "Please will someone get me up?" This person made the same plea four times during the handover meeting, but none of the staff responded until the meeting was finished. The registered nurse also shared detailed information about people to staff in the corridor, which could have been overheard by visitors.

We were taken on a tour of the home by the manager and visited Gordon and Fraser units in one half of the building. During the tour, we heard one person calling out, "Help me, will someone please help me?" The manager walked past the room and did not respond. We entered the room and the person said, "Please help me, I'm in pain". We called the manager who then came to the room and waited until a member of care staff came to assist.

We observed one person walking in the corridor who was confused about their clothes. They had put on a long dressing gown. Two staff did not notice this person's confusion and need for support. One member of staff went off to open the door, saying, "Just a minute", but did not actually return to the person. It took a third member of staff to provide the support needed. This was then done kindly with the staff member walking with the person arm-in-arm to check out their clothes and reassure them they were there to help.

Another person said, "I'd like to go for a walk". The response from staff was, "Next time there's a bus trip, we'll see if you can go on it. I know it's not the same as a walk. I'll mention it to your family at the weekend and see if they can take you for a stroll".

We observed one person who found the light very bright in one of the sitting rooms. Staff offered them a change of chair in another less sunny part of the room. Staff were overheard to say that this lady was probably finding the light too bright because eye-drops had been administered. There was no reassurance from staff or any kind of offer of support given to the person who was in distress.

Almost without exception, at lunchtime, people wore clothes protectors rather than being offered a serviette. In some cases, clothes protectors did not appear to be needed, with people eating and drinking confidently and no spillages. Some people were not asked by staff if they agreed to wear a clothes protector or not. During lunch, one person repeatedly wanted to go to their room and kept asking to leave. The person was actively encouraged to stay for lunch and did eat some lunch, despite saying they had not wanted any. At the end of the meal though, they said, "Can someone take me to my room now please?" They were told by a member of staff, "We haven't finished lunch yet" and the person responded, "Well I have and I'd like to go to my room". The staff member replied, "We have to wait for everybody to finish and then we'll take you upstairs".

Another person was repeatedly trying to get up to leave the table, having eaten their first course, but was gently pushed by staff back to the table. This continued for around 45 minutes. At the end of lunch, other people left the table freely, but this person was unable to leave without staff support. Eventually, a member of staff said, "Are you going to eat some more pudding?" The person declined initially, until offered a yogurt, which they accepted. The person was still sitting in the same chair at the dining table at 2.10pm (lunch having started at 12.30pm).

We observed staff talking over people as though they were not there. When tea was offered in the afternoon, care staff were about to offer a slice of cake to one person, then changed their mind saying over the head of the person to another member of staff, "I think she's diabetic, I'll find out".

This shows that people were not always treated with dignity and respect. People's expressed choices and preferences were not respected or considered by staff. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us about their family member and said, "A big part of their life is the church and they have a service here, but we don't know if [named family member] goes or not". In conversation, the relative said, "We just don't know what's going on. There's a communication book, but [named family member] is hiding it and it doesn't get used. We can't always ask anything as there's not always anyone around who knows what's going on. There's a wipeboard in their room [referring to family member], to remind them

Is the service caring?

when we're coming to take them out, but then we arrive and, having said not to give them lunch, there they are sitting at the table having lunch. They are very caring, but we just hope they will learn from this. It's been so stressful and we've had to keep saying things over and over".

It was difficult to see whether people's individual needs were always acknowledged and recognised. One relative told us, "Church was a big thing in their life [named family member], but I don't think it matters any more with having dementia". Church did not now appear to feature in this person's life.

Most people were unable to recall being involved in any discussions about their care plans or in decision making about their care. One relative did say that care plan reviews took place and that they were consulted with, but other relatives said they were not involved in any such discussions. Relatives did, however, say that communication was good and the home kept them informed. However, another relative was not so positive. They told us, "We didn't get together [with staff] and talk about a care plan or anything until about four weeks after [named family member] had been here. We thought there would be something before this and it only happened because we were pushing for it and then the life story book was done after about six weeks. When they'd done it, they said it was really useful and that maybe everyone should have one". They added, "When we finally saw a care plan, there were things that were just wrong. It was an automated one, not personal to [named family member], just tick boxes. They'd ticked that [named family member] was able to communicate effectively which is the only thing they absolutely can't do. It said she needed a shower once a week, but that's not right and so she gets one more regularly now".

We asked how staff sought to involve people with their care and we looked at people's care plans and daily records. We found no evidence that people or their representatives had regular and formal involvement in care planning or risk assessment. People's views were not sought, consequently, there was no opportunity to alter care plans if the person did not feel they reflected their care needs accurately.

This shows that people or their representatives were not always involved in the assessment or review of their care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People considered staff to be respectful and that they were treated with dignity. This was evident as staff knocked on people's doors, waited and used people's preferred names. We observed staff hung a 'Care in Progress' sign on people's doors when providing personal care, to avoid someone entering unnecessarily and causing embarrassment. A relative explained how they felt their mother was treated with dignity. They said that she was always nicely dressed with matching clothing, that she wore jewellery and that staff had supported her to do this.

We asked staff how they supported people to maintain their dignity and privacy. One staff member said, "This is a big place, so it's easy to forget it's people's homes. I always have that in mind". Another staff member said, "We do our best in that regard, but we're so busy getting things done, I'm not sure we have the time". A third staff member said, "I think if people can do things for themselves, then we should and do encourage that".

On the positive side, many people felt that staff were kind and caring. Comments were, "We're looked after well we are", "I do really think they are kind and caring, yes" and "Any of them will give you a hand". Some staff were bright and chirpy in their approach, with a willingness to respond to requests in a kind and pleasant manner. Staff were clearly comfortable at offering reassurance, both verbally and with gentle and appropriate physical contact, such as holding hands or a gentle arm around the shoulders. Once engaged, staff spoke with people at their level, giving good eye contact and listening to them. One staff member said, "You all right there? Let me know if it gets chilly". Another staff member said, "Yes, I'll get your handbag for you … here it is" and "[Named person] can I adjust your hairband for you, it's slid down a little bit". People had no concerns about the gender of the care staff providing personal care, but said they had not been asked for their preference.

Four care plans contained a section which included advanced decision making. Advanced decisions are made by people in collaboration with their relatives or representatives and provide information about how they want to be cared for as they reach the end of their lives. Information included whether the individual wished to be resuscitated in the event of a cardiac arrest. The care plans for those who did not wish to be resuscitated contained

Requires improvement

Is the service caring?

documentation indicating this, as required by law, and was countersigned by the person's GP. Staff displayed a good level of knowledge of advanced care planning and were aware of people's needs in this regard.

Requires improvement

Is the service responsive?

Our findings

All care plans and risk assessments were reviewed monthly and signed by staff. We asked a relative if they felt person-centred care was delivered by the home. They told us, "Definitely, yes. I told the staff when my relative came here that she wasn't sociable or particularly mobile, but she is both now. The manager also makes sure I'm kept up to date with what's going on. I don't come in and find something happened three days ago and this is the first I know about it".

We asked staff what they understood by the term 'person-centred care'. One staff member said, "Well, it's putting the resident at the centre of what we do". Another staff member told us, "I know what it means, but I don't think we always have time to do it".

We looked at the care plans and daily records for five people. These were legible, up to date and personalised. Care plans contained detailed information about people's care needs. However, the care plans did not contained detailed information about people's personal histories and their likes and dislikes. We were told by staff that this was kept separately and we observed there were other folders kept on an open shelf which contained this information. People's choices and preferences were documented in their care plans. The daily records showed that these were taken into account when people received care, for example, in their choices of food and drink. Care planning and individual risk assessments were reviewed monthly or more frequently if required and were up to date.

People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan. Care plans were regularly updated in line with people's changing needs. There was good communication in the management of people's care between the provider and external professionals such as GPs and community nurses.

People said that their relatives could visit at any time and were made to feel welcome. One person said, "My daughter comes in and says you can't beat the place". A relative told us, "I'm always made welcome and if [named family member) wasn't happy, she wouldn't be here".

There were some organised activities available to people and there were opportunities for people to engage in activities at one of the provider's other locations. On the day of our inspection, a game of Scrabble was enjoyed by people in one of the units. In the afternoon, a quiz based on 'Twenty Questions' was in progress in another unit. However, whilst two or three people were engaged with the game, the majority of people were either watching passively or were asleep. A member of staff stood at the front of people who were sat in a circle in armchairs. The staff member tried to encourage people to respond and gave various hints and clues to elicit interaction. However, the majority of people did not appear to understand what was required of them. Whilst the game was in progress, other staff came round and started serving people with afternoon drinks and cakes. This was quite disruptive for people trying to concentrate on the game, but seen as a welcome relief by others. One person thought the game was, "Rather boring".

In the Richmond unit, we observed two people at separate times having one-to-one support from staff as they were doing some colouring. However, other people were either dozing, in bed or having a walk to and from their room. One relative told us, "[Named an ex-member of staff] used to work in here and brought it to life. They'd use the tearoom and be doing people's hair, that sort of thing. But I think the tearoom is used more for staff now and you feel like you're intruding".

We recommend the provider review the programme of activities planned to ensure they are person-centred and meeting the needs of people, including those who are living with dementia.

The service had a system in place for acting and dealing with complaints. A number of complaints had been raised during the year and meetings had taken place between the complainant and management. Records showed that complaints had been addressed, in the main, to the satisfaction of the complainant and lessons had been learned.

A number of compliments had also been received from relatives. One relative had written, 'As you know, choosing a care home is a really difficult task and one that we found very challenging. However, we couldn't have made a better choice and I know that Dad was very happy with you and felt cared for with respect and courtesy". Another relative stated, 'We would like to say a huge thank you to all of the staff at Linfield House for the abundant kindness, concern, love and sympathetic care you showed our mum".

Requires improvement

Is the service well-led?

Our findings

People's personal information was not always kept in a confidential way. Information and personal histories were kept in folders on an open shelf in the nurses' station and the office door was wide open. On the wall was the computer password for agency staff which gave access to confidential information about people held on the computer. There were also details about GP visit dates and medicines delivery dates posted up on a noticeboard which could have been seen by anyone.

The service had a range of systems in place to measure and monitor the quality of care delivered. Audits addressed the regulatory requirements under the headings used by CQC in 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well Led' and a peer review process meant that managers audited each other's homes. The audit record showed the regulatory requirement, the evidence supporting this and any improvement actions that had been identified following the audit. Audits had been completed in November 2014, February 2015 and May 2015. Following the audits, a continuous improvement plan had been put in place which identified the improvement action and gave a date for completion. However, whilst some dates were completed to show when the improvement action needed to be completed, other actions were noted as 'ongoing'. The columns headed, 'Progress against action' and 'Date completed' were left blank, so it was difficult to ascertain whether the actions identified had been completed or not.

An audit undertaken in November 2014 had identified that there was a high level of sickness from staff at weekends, which put pressure on the staff that were working. However, the audit had not identified that staffing levels deployed were insufficient to meet people's needs. Nor had it identified that staffing levels could have been assessed more accurately, based on people's needs, by the use of a dependency tool. People also felt that staff were sometimes too busy to have time to sit and chat with them. Some audits showed that the home had awarded themselves a rating of 'Good' across each area. However, the audits seen did not identify the areas of concern that we found during this inspection.

This shows that personal information about people was not kept confidentially or securely. The provider did not have an effective system to assess, monitor and improve the quality and safety of the services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits showed that accidents and incidents had been analysed to determine trends. Action had also been taken following issues identified in an audit on infection control.

People said they felt this was a well run home with a culture of speaking up about any issues or concerns and that the management were approachable. One person said, "I can confide to the 'guvnor' any time" and, "It's a nice atmosphere in here". Meetings were held on a monthly basis so that people and their relatives could meet up and give their feedback about the service. A meeting held in August 2015 showed that activities, hairdressing, staff levels and people joining and leaving the service had been discussed. However, there was no evidence to show what action had been taken as a result of each meeting and how this was followed up.

We asked staff about duty of candour and its relevance to the care and support of people living at the home. Duty of candour forms part of a new regulation which came into force in April 2015. It states the providers must be open and honest with people and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to people in relation to the incident. Some care staff were aware of this regulation and were able to describe its relevance and application.

We asked staff about the vision and values of the home. One staff member said, "We have a great team here I believe, but I don't think the management appreciate it". Another staff member told us, "Staff are leaving because they don't feel well supported. I think it goes beyond the home".

At the time of our inspection, the manager had not completed their registration with the Commission, but was in the process of doing so. We asked staff about the day-to-day running of the home and how the manager led the service. One staff member said, "We never see the manager. They're in the office and that's it". Another staff

Requires improvement

Is the service well-led?

member told us, “The manager is okay if you go to the office, but I feel we are left to get on with it. I’m not sure it’s the manager’s fault that we are so short-staffed, I think it’s higher than that”. We discussed this with the manager who felt these were unfair comments. She told us that she always attended the handover meetings on the floor between shifts. However, staff did not feel she had a real understanding of the day-to-day delivery of care in practice or observed how people were being cared for.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were insufficient numbers of staff to enable them to carry out the duties they were employed to perform. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: Service users were not treated with dignity and respect. Regulation 10 (1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Service users' records were not kept safely and were accessible to people not authorised to deliver their care and treatment. The provider did not operate an effective system to ensure compliance and monitor the quality of the service provided. Regulation 17 (1) (2)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People or their representatives were not consulted about the care and treatment given or enabled to understand the care and treatment choices available.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 9 (1) (3)(a)(b)(c)(d)(e)(f)(g)