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Lindenwood Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 11 July 2018 and was unannounced. Our last inspection of this service was on the 12 and 13 April 2017 and we found the service required improvement in the safe and well led domain. The service had not assessed potential risks to the safety of the premises or taken appropriate action to mitigate such risks. Governance systems were not adequately robust to ensure effective monitoring and improvement of the quality and safety of the service. We found the service was good in the effective, caring and responsive domains.

We returned to the service on the 5 October 2017 to complete a focussed inspection and found the service was good in the safe and well led domains. Further information about this inspection can be found in the body of the report.

Lindenwood Residential Care Home is a "care home" providing care for up to 16 people in the New Moston area of Manchester. People in care homes received accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

There were 14 people living at Lindenwood Residential Care Home on the day of inspection.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left the organisation in February 2018. The current manager had worked at the organisation since May 2018 and told us that they were beginning to process their registration with the Care Quality Commission (CQC).

At this inspection, we found concerns relating to the stock management of medicines, risk assessments and there had been no fire drills recorded since the last inspection.
Stocks of medicines were not clearly recorded. Medication administration records (MAR) has been completed appropriately.

Amounts of medicines in stock were not clearly recorded, However, we saw that medicines were administered in line with the prescription. Medication administration records (MAR)had been completed appropriately.

Peoples fall risk assessments required further work to assist in the prevention of falls. Nutrition and skin integrity risks were monitored and any concerns reported promptly.

Staff were recruited safely and were aware of their responsibilities in ensuring that people were kept safe. Staff understood safeguarding procedures and could describe action to take in the event of suspecting

abuse. Staff felt confident that any allegations they raised would be taken seriously and people living at the home were confident they could raise any concerns they had. Staff were aware of the whistleblowing policy and why it was in place.

Checks of premises were in place and in date. The service had not ensured fire drills were always completed.

Staff were given an induction and training relevant to their job role. Staff felt that training was good and complemented their role and they told us they enjoyed learning. Staff received supervision but it was not regular, however, the new manager was in the process of developing a supervision plan. Staff meetings had not always been held in a timely manner.

The service worked in line with the Mental Capacity Act 2005 (MCA) and people received capacity assessments. Best interest's meetings were held for people to assist them to make decisions. Staff gained consent from people when supporting them with personal care or administering medicines.

Dementia signage had been introduced throughout the building and there was a secure garden for people to access safely.

A ground floor bathroom was being tuned in to a walk-in shower room. This meant that people had the choice of a shower or bath and could easily access the shower if they have mobility difficulties.

There were caring and kind interactions between staff and people using the service. The manager and registered provider knew people well and the atmosphere was calm and pleasant. People told us the staff were very caring and we observed meaningful conversations, people were laughing and joking.

Care plans were detailed and captured peoples' personal preferences. Care plans gave information to staff to enable them to support people safely and to ensure they retained independence. A 'This is me' document gave life history information and was used as hospital passport to inform health professionals of details to support people while they were in hospital.

There was a programme of activities and an activity organiser to coordinate activities and spend time on a one to one basis with people.

People could be supported at the home at the end of life and the home worked with health professionals to ensure people's choices were respected. Detailed end of life planning was in place to ensure people had their preferences and choices respected at the end of their life.

The service had received no complaints since the last inspection and a number of compliments had been received thanking the staff for the care received for a relative or friend.

There were audits in place to monitor and improve the service. The manager was developing an action plan of things they wanted to improve.

The service sought feedback on what it offered.

Staff felt well supported by the new manager and the registered provider and both were visible across the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service is not always safe.

Amounts of medicines in stock were not clearly recorded, However, we saw that medicines were administered in line with the prescription.

Fire drills were not always undertaken to ensure staff and people knew how to respond in an emergency.

People's risk assessments required further work to mitigate risk to keep them safe.

Is the service effective?

Good

The service is effective.

People received support and choice with food and nutrition.

The service acted in accordance with the Mental Capacity Act 2005.

Staff received appropriate induction and training to enable them to carry out their job role.

Is the service caring?

Good

The service is caring.

We observed kind and caring interactions between people and staff members.

People felt well cared for and that staff maintained their dignity when supporting them.

Staff were observed to be aware of people's preferences and choices such as how many sugars in a hot drink and where people preferred to sit.

Is the service responsive?

Good

The service is responsive.

People were able to join in activities in and away from the home.

Care plans were detailed and person centred and involved people.

The service had received no complaints since the last inspection and there were processes in place to monitor complaints.

Is the service well-led?

Requires Improvement

The service is not always well led.

Further work was required to personalise policies to the service.

There were some audits in place to monitor and improve the service however medicines were not audited as the computerised system used had failed and there were no systems in place to continue with monitoring of medicines.

Staff felt supported by the new manager and registered provider.

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 on 11 July 2018 and was unannounced. The inspection was undertaken by one adult social care inspector.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the provider about incidents and events that had occurred at the service. Statutory notifications include information about important events, which the provider is required to send us by law. We used this information to plan the inspection.

We contacted Manchester local authority commissioning, safeguarding and public health teams to obtain their views of the service and to collect information they held such as safeguarding referrals and infection control audits. There was no information of significance raised. We also contacted Manchester Healthwatch who told us they had not received any feedback about this service so far. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services.

During the inspection we spoke with three people who used the service, the manager, the registered provider and three staff members.

We looked at three care plans and risk assessments. We reviewed two staff personnel files and records relating to recruitment, induction, training and supervision. We looked at five people's medication records and a number of audits relating to medication management, health and safety, infection control,

recruitment, safeguarding and quality assurance. We checked people's feedback on the service including if people felt cared for and whether people were involved in planning their care. We looked at health and safety and infection control and medication management. We reviewed policies and procedures and business continuity planning.

We also completed a 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.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in May 2017 of Lindenwood Residential Care Home, we found that although improvements to risk assessments had been made, clear directions for staff to manage the risks were not available for them to follow. We also found a number of risks relating to the safety of the premises. We returned to the service in October 2017 to complete a focussed inspection and found that risks to the service such as storing combustible materials, storage of cleaning products and bedding were well managed and not accessible to people who lived at the service. We also saw that risk assessments for people had improved and were being regularly reviewed.

As part of our inspection, we viewed five medicines administration records (MAR) and observed a care worker administering medicines to people. The service had been using a Proactive Care System (PCS) to support the administration of medicines to people. The PCS offers automated checking process to ensure care home staff give the right medication at the right time to the right person using bar code technology. It also provided stock control and the ordering and booking in of medicines. A week prior to our inspection, the computerised part of the system had failed and the service had needed to return to handwritten or pharmacy printed medication administration records (MAR).

Of the five MAR charts we looked at, we found one person had a handwritten chart with no stock level booked in. Two people had stock levels recorded on the MAR chart at the start of the medication cycle but this did not reflect the amount of medicines remaining in the box. For example, one person had 28 tablets booked in and 16 tablets had been administered which meant there should have 12 tablets remaining in the box and there were actually 20 tablets remaining. This was the same for a number of medicines that we checked.

Where stock was recorded on the MAR chart, it only reflected the medicines that had been sent to the service for the current medication cycle. The service had not factored in any remaining stock to ensure numbers of medicines available were clearly reflected on the MAR chart. We discussed this with the manager and a senior care worker and advised them to count the number of each medicine in stock and record it on the MAR which can then be used for effective auditing. We have since received evidence that this was completed following our inspection.

We found the remainder of the MAR charts to be appropriately filled in with photographs of the person on the front. Medicines had been given in line with the person's prescription. Also, a body chart accompanied the record and gave directions for the location of the cream to be applied. All creams administered had been signed for on the MAR chart and directions for creams were also recorded in people's bedrooms.

Protocols were in place for the safe administration of "when required" medicine. When required medicine is a medicine such as Paracetamol, which is not routinely required daily. The protocols gave guidance to staff for the signs and symptoms people may display when in need of this medicine. This meant staff were able to monitor people who didn't communicate by looking at other changes in their health and wellbeing.

Senior care workers and care workers received medication training and their competency had been assessed by the previous registered manager annually. Staff we spoke with confirmed that they had received training and competency assessment. Training certificates were kept on staff files while competency assessments records had been stored on the PCS system.

Regular temperature checks were recorded for fridge and room temperatures which ensured that medicines were stored at the correct temperature.

We received copies of the medication audits undertaken at the service after the inspection. The audits were completed by a senior staff member prior to the PCS system failing, however, the audits did not identify checks of the running total of medicines kept in stock. The service were also going to request the pharmacy to review and audit the medicines at the service.

People we spoke with said they felt safe living at Lindenwood Residential Care Home. People told us, "Yes, I feel safe and looked after, I came here after I had a fall" and "Yes, I am safe, I couldn't be better taken care of." People told us they would make any concerns they had to the manager, staff or their family. One person said, "I would tell my daughter, she would sort it out but I am fine."

The service had safeguarding policies and procedures for managers and staff to follow if required. All the staff we spoke with could describe what action to take if they suspected abuse was occurring and each staff said they were confident the manager or provider would listen to their concerns and deal with it appropriately. We saw that staff had received training in safeguarding vulnerable adults from abuse. Staff we spoke with confirmed this and there were certificates confirming that training had been attended. Staff were aware of the whistle blowing policy.

We reviewed two staff personnel files and saw they had the required pre-employment checks in place including two written references and a Disclosure and Barring Service (DBS) check. This meant the service had ensured staff were of good character and suitable to work with vulnerable groups.

There were sufficient numbers of staff to support people with their assessed needs during the day and night. People told us that they were able to get up and go to bed at a time they chose and there were always enough staff available to support them. All staff we spoke with said there was enough staff on duty.

Agency staff were used to backfill positions to be filled by permanent employees. Regular agency staff supported the service and the provider had ensured appropriate checks were in place to ensure the agency staff had received suitable references, a DBS check and been trained.

We observed people who required equipment such as a hoist to move, were supported in a reassuring manner by two staff members. Falls were monitored using a falls risk assessment which gave information on how the risk should be managed for example, with assistive technology such as sensor mats. We saw that where people were at high risk of falls in bedrooms, then sensor mats were provided to alert staff that people were mobile in their rooms. There was no assistive technology in use outside of the bedroom environment.

We looked at information relating one person who had fallen at the home. The person was considered to be at high risk of falls and required monitoring when mobilising. Whilst there were risk assessments in place to monitor the person when they were in their bedroom and assistive technology was used to monitor when the person was out of bed. There was no management of the risk while the person was present in the communal areas such as a chair sensor. We recommended that the provider refer to current best practice

relating to falls prevention.

People were assessed for their risk of malnutrition and we saw that where weight loss was a concern for one-person, appropriate referrals had been made to health professionals and the person was assessed and placed on a pureed diet with thickened fluids. Staff were giving training to administer thickened fluids and we observed they followed the instructions for use when using food and fluid thickener. All people living at the service had a pressure relieving mattress and there were regular documented body mapped checks of people's skin integrity. We saw where there was a concern with skin integrity, then appropriate health advice was sought.

Accidents and incidents occurring at the home were recorded and but there was no evidence of any action taken to reduce the risk of any future occurrences. This meant that accidents or incidents could potentially occur again. We recommend the home reviews this. Body maps were in place which identified where any injuries had been sustained.

During the inspection we asked to view the records in relation to fire drills at the home. We noted there was no record of fire drills recorded at the service, staff members we spoke with could describe in detail how they would respond to a fire and where the meeting point was should the building need to be evacuated. Since the inspection, we have received confirmation that a fire drill has taken place with the staff team and going forward, fire drills will occur more often.

The provider did not proactively review accidents and incidents to prevent future occurrences. The provider did not ensure regular fire drills were undertaken to assist the staff with knowledge of fire evacuation.This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were systems in place to protect people in the event of an emergency. Personal emergency evacuation plans (PEEPs) were in place for all people who used the service and a grab file copy was kept in the office. The plans gave detailed advice on how best to support people, particularly with mobility problems in the event of an emergency.

We saw equipment had been serviced according to the manufacturer's instructions. There were weekly internal checks of the fire alarm system, emergency lighting, nurse call alarms and water temperatures. We viewed servicing certificates which were in date for gas, electrical installation, fire alarms, emergency lighting, portable electrical equipment (PAT) and hoist. The service had appointed an external organisation to manage the passenger lift. There were documents in place confirming that the lift had been serviced at regular intervals. A fire risk assessment was in place. A legionnaires risk assessment was in place. Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria that can develop in water systems. Regular running of infrequently used water outlets can reduce this risk.
We observed staff using personal protective equipment (PPE) such as gloves for use when delivering personal care. We also saw that PPE was readily available within the home. We saw that the service had an infection control policy in place and staff confirmed to us that they were aware of the requirements of the policy. Certificates were in place confirming staff members had received training in infection control.

Cleaning records were completed daily and we saw records relating to monthly checks of mattresses and cushions. We found the service to be clean throughout and were assured that the service was taking necessary action to prevent the spread of infection.

Good

Is the service effective?

Our findings

The mealtimes we observed were relaxed and well organised. People received any help, support and encouragement they required to eat and drink promptly. We saw people were offered a choice of meals and were asked if they had had enough to eat. One person told us "The lunch is very nice, I can choose what I eat, we tell them [staff] what we like and they bring it for us." Another person told us, "I never had breakfast before I came to live here and now I eat a boiled egg, it's great."

During the meal we also saw that care workers promoted people's independence by encouraging them to eat meals by themselves; however, when it was clear that people couldn't manage or required assistance it was provided promptly. We observed a staff member offering to cut a person's chicken up when they were struggling.

Menus were available on each dining table which provided a good variety of food to the people using the service and people could choose where they ate their meals. Tables were set with condiments and juice and people could request an alternative drink if they wished.

Each person we spoke with said that they enjoyed the food they were being offered at mealtimes. Care plans gave information on people's specific diets, type of diets and if they ate independently. We saw people being encouraged to eat a healthy diet and those at risk of malnutrition ate a fortified diet. This was under the advice of a dietician or other health professional. Staff we spoke with were aware what type of diet each person had such normal, soft or pureed. We also saw that people's weights were regularly monitored. This meant that people were given choices for their food preference and that any concerns around eating or drinking and weight loss were acted upon. There was fresh fruit available for people to help themselves to.

We saw that people were seen by health professionals such as GP, district nurse, chiropodist and dentist when required. People told us that if they felt unwell, the staff would ring a doctor for them. People were supported to attend hospital appointments if family could not attend and detailed recordings were made in the notes of any outcomes of the visits.

Staff told us they were up to date with their training. Training included moving and handling, safeguarding, deprivation of liberty safeguards, mental capacity, nutrition, food safety, continence, medication, fire safety, dementia awareness and first aid. One staff member told us that they complete distance learning work books for training as well as e-learning and that the training was good and relevant to their role.

We reviewed staff files and found that that staff received an induction into the service and staff members confirmed this. We saw induction included mandatory training and the opportunity to shadow more experienced staff members. Staff told us and we saw that they received regular supervision and were able to attend regular staff meetings. We saw staff meeting minutes for the day staff but for night staff, there were only one meeting recorded for the last 12 months. Minutes were recorded for a recent staff meeting with the new manager for all staff. The manager said they would be setting up regular staff meetings going forward. We will review this at the next inspection.

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.

The manager had a good understanding of this legislation and appropriate assessments of people's ability to make decisions had been completed.

Where people's capacity to make a specific decision could be variable this had been recorded and staff were provided with guidance on how to support people to make meaningful choices. 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). The service was acting in line with the Mental Capacity Act 2005.

Staff we spoke with were aware of the MCA and DoLS and we saw that they had received training. One staff member told us that they understood the need for gaining consent from people and always gained consent when administrating medication to people to ensure people were aware of what they were taking.

The home ensured that only those with legal authority could consent to care and treatment when a person lacked capacity. We saw that one person had been part of a best interest's decision when their swallowing had worsened. The GP had offered another alternative to receiving food and fluids which the person declined. A capacity assessment and a discussion was held with the person where it was felt that the person had capacity and was able to understand the risks and this was clearly documented.

We saw that dementia signage had started to be implemented throughout the home. This included names on bedroom doors as well as photographs of people's choice such as a person's favourite football team. This helped people identify their bedroom. Dementia signage is specifically designed to aid comprehension for people with dementia using words, colour contrast and pictorial images to aid understanding. Additionally, signage was displayed on toilet doors and bathrooms and communal areas. This gave people living with dementia, maximum opportunity to find their way around the home.

Within the home, there was a large lounge and dining room. A large, secure garden was at the rear of the property which people could access with support from staff. There were ramps placed around the home to enable people with reduced mobility to access the garden. We saw that people were able to furnish their bedrooms as they wished and many rooms had photos of relatives and friends on them. All bedrooms had sinks for people's personal use.

Chairs and beds were fitted with pressure relieving equipment such as cushions and mattresses to assist in the prevention of pressure ulcers occurring. This meant that people who were at risk of pressure sores were assisted to relieve any symptoms from occurring. Staff members we spoke with told us that they regularly repositioned people if they were unable to move themselves. This assisted in protecting people's skin integrity. Hand rails were available throughout the home and a ground floor bathroom was in the process of being turned into an accessible walk in shower room.

Good

Is the service caring?

Our findings

We observed kind, dignified and caring interactions between people and the staff working at the home. People looked at ease with staff supporting them and there were often friendly conversations to be heard and people looked happy and relaxed.

People were very complimentary about the staff team and told us, "The staff are kind, I get on with them, [Name] takes me out for meals." "Staff are nice and helpful, they help me to keep my room clean and tidy." "The staff are lovely and [Registered provider] is here every day."

Staff members were observed to have the time to sit with people and spoke to them in a manner people could understand. Although the manager was new in post, they were clearly aware of people's needs and responded to people in kind and considerate manner. The registered provider was a regular visitor to the home and assisted in the day to day care of people. The registered provider was aware of people's needs and was observed assisting with meals and care needs throughout our visit. One person told us, "[Registered provider] is lovely, they always have a laugh with me."

Staff told us that they were aware of how people's privacy and dignity should be protected. One staff members said, "I always cover people up where possible when completing personal care." We observed staff knocking on doors, offering help to people with the cutting up of food, offering the use of clothes protectors such as aprons at meal times and assisting people with mobility. Staff were aware of people's personal preferences and were aware of who liked to sit with who at the dining table and those people who liked to eat in the lounge area.

Staff we spoke with said they encourage people to do as much as they can for themselves while keeping them safe. Details of things people could do for themselves were recorded in the care plans and instructions were clear for staff to see what help people required. One person told us that they can get themselves dressed and staff might tell them what the weather is like so they know which clothes to wear. People's preferences, likes and dislikes were recorded in their care plans. The staff we spoke with knew the people they were supporting well and were able to describe their routines and preferences, for example, staff knew how many sugars people wanted in their tea or who preferred juice with their meal.

We observed that staff called people by their preferred names and this information was also recorded in people's care files.

We saw that care files were stored securely in a locked cabinet and only accessible to staff working at the service.

Good

Is the service responsive?

Our findings

The home had an activities organiser on site Monday to Friday and we observed they were friendly and encouraged people to get involved. One person enjoyed playing dominoes and we observed a lively game where other people joined in to spur the person on to win.

We saw a regular programme of activities such as arts and crafts, games, armchair exercises and one person enjoyed painting. The staff also supported people to go out for meals and one person told us they were planning to go to Blackpool and that singing groups visited the home.

People were supported to celebrate special birthdays and the home frequently held parties and invited the person's family and friends to join them.

People received one to one time with the activities organiser and this time was used for reminiscing or hand massage. We noted people could spend time in quiet area's reading a book or newspaper. There were twiddle muffs available for people living with dementia. Twiddle muffs are double thickness hand muff with bits and bobs attached to the inside and out and is designed to provide a stimulation activity for restless hands in people living with dementia.

We reviewed three peoples care files and found that each person had received a documented pre-admission assessment prior to moving into the home. This included looking at mobility, eating and drinking, moving and handling, health and medication needs. Care files contained care plans which were personalised to people's needs. The care plans described what help people needed with mobility, continence, personal hygiene, behaviour needs, capacity, eating and drinking and dementia. Care plans were reviewed monthly or as changes were noted in people's needs.

Staff we spoke with could clearly describe what care and support each person required and told us that they were always informed if care plans were updated.

People had a 'This is me' document which discussed people's life history including family and working life and included likes and dislikes. The information was also used as a hospital passport which gave hospital staff valid information on people, should they need to be admitted. For example, information pertaining to how people received food and drink such as a pureed diet was recorded. Additionally, information on how to communicate with a person or what action to take should a person become distressed was also recorded within the document. This document was invaluable to the professionals caring for people who did not fully know their needs.

We saw that care files contained information relating to peoples wishes once they reach the end of their life. This included recording of any persons to be contacted, any religious preferences and what arrangements for the funeral the person would like to be made. Some people living at the home had a Unified Do Not Attempt Cardio Pulmonary Resuscitation (UDNACPR) form in place. A UNADCPR is used when a medical professional and the person or their legal representative agree that resuscitation would be unsuccessful.

This meant that people's wishes at the end of life could be carried out respectfully. Where people had decided they wanted to remain at the home for care and support at the end of the life, this was supported by the district nursing team. We saw that one person was being supported at the end of life in and staff were making regular checks on the person and monitoring them for pressure area concerns and changes in their health.

There was a complaints policy in place and people told us they knew to speak to the registered provider or manager if they felt they needed to complain. The home had received no complaints since the last inspection. Staff told us they would refer any complaints they received to the manager. This meant the home had a process in place to manage to complaints before they escalated to a more serious matter,

The home had received a number of compliments thanking the home for the care and support of their relative or friends. One compliment said, 'I have complete faith in the care given to my mother, I couldn't have asked for more.'

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2017 we found there was a lack of auditing of the quality and safety of the home. We returned to the home in October 2017 and found that improvements had been made to audits of the premises safety and further audits had been implemented to monitor and improve the quality of the home.

Audits of the premises were completed monthly which included checking of fire escape routes and firefighting equipment, that equipment was serviced and a walk around was completed of the home. The new manager had spent time auditing the service and noting what needed to be put in place and was devising an action plan with time scales to assist in monitoring and improving the home. We will review this at our next inspection. Audits of medicines were unavailable due to the failing of the Proactive Care System (PCA) which meant that stocks of medicines could not be accounted for.

The provider did not have systems in place to be able to monitor stock levels of medication in the eventuality of the PCS failing. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The home did not have had a registered manager in post as required by their registration with the Care Quality Commission (CQC). The previous registered manager had resigned from the post in February 2018 and a new manager had been appointed and was in the process of submitting their registered manager application with CQC.

The manager was supported by two senior staff members and a team of care staff. We saw the registered provider visited the home often and we observed that they knew people living at the home well. The home had staff members working that had been there for a number of years. Staff were complimentary of the new manager and felt that they were taking the home in the right direction.

The new manager had completed one staff meeting since being at the home and had plans in place to meet with staff more often and complete regular supervision.

The previous registered manager had asked people and their representatives to complete questionnaires to enable them to monitor and improve the service. The last response was collected in September 2017 and nine people had completed the document. We saw that all people said they felt respected and were treated as an individual. All respondents said they received good support from staff and said they were involved in decisions. People also confirmed they were able to make choices and preferences. One comment in the questionnaire was that messages aren't always passed on. We were not clear what had been done to resolve this and improve communication from the respondent's point of view as this questionnaire was received by the previous registered manager. The new manager was in the process of producing questionnaires for people to give their feedback on the service. We will review these at the next inspection.

We saw policies and procedures were in place for safeguarding, recruitment, mental capacity, end of life,

infection control and whistle blowing. Policies had been produced by another organisation so were not generally specific to Lindenwood Residential Care Home but were specific to care services. We recommended that policies were reviewed to ensure they are specific to the provider. Policies were reviewed annually.

We saw that a business continuity plan was in place to assist in managing the service in the event of a power cut, flood or if at any time people needed to be moved to a place of safety. This meant that there were plans in place to continue the running of the service during periods of disruption.

We saw that all statutory notifications had been sent to CQC in a timely manner.

We saw that the service displayed the last inspection Care Quality Commission (CQC) rating within the home. This is a legal requirement for any premises providing a regulated activity.

At the last inspection, the overall rating for the service was good. At this inspection, we found that the service was overall requires improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not proactively review accidents and incidents to prevent future occurrences. And The provider did not ensure regular fire drills were undertaken to assist the staff with knowledge of fire evacuation. And The provider did not have systems in place to be able to monitor stock levels of medication in the eventuality of the Proactive Care System failing.