Anchor Trust

Linwood

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 June 2015. At that inspection a number of breaches of legal requirements were found. As result the service was rated inadequate overall and this provider was placed into special measures by CQC. As part of this decision, we met with the provider to discuss our concerns. We also issued two Warning Notices which required the provider to take immediate action in relation to staffing levels and the governance of the home. We undertook this focused inspection to check that this action had been taken. This report only covers our findings in relation to whether the service is Safe and Well Led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Linwood on our website at www.cqc.org.uk . The service remains in Special Measures and we will be re-inspecting to make sure that improvements have been made and are sustained.

This inspection found that the provider had taken immediate action to rectify the serious concerns we raised about the service in June 2015. Improvements to staffing levels and the way the home was being managed meant that the provider had complied with the Warning Notices we had issued. We also saw that work was continuing to address the other breaches in legal requirements, although we also identified some new breaches. CQC is therefore now considering the appropriate regulatory response to monitoring this provider going forward.

Linwood is a care home that provides personal care for up to 67 older people, some of whom are living with dementia. The home is divided into six units across three floors. Each unit has its own communal space. A large garden is located to the rear of the home.

Summary of findings

This inspection took place on 28 September 2015 and was unannounced. There were 61 people accommodated at the home, one of whom was in hospital at the time of our visit.

The home had 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.' Since our last inspection, the registered manager had however not been working in the home. The provider had been overseeing the management of the home during this time and a new interim manager had recently been appointed.

The interim manager had a good knowledge of the home and was working in partnership with the provider to complete an action plan for improvement. Both the provider and the interim manager had been open about the shortfalls at Linwood and how these were being addressed. We identified that there was a gap between the leadership from the provider and the day to day monitoring of care practices. The action plan for the home had also highlighted this issue and the interim manager was clear about how this was being managed.

We found that there were some occasions when people had not received their medicines as indicated on their Medication Administration Record (MAR). In two cases this was because recent advice from the person's doctor had not been reflected on the MAR. In other cases it was due to staff not correctly recording the medicines they had administered.

We found that a number of new staff had been recruited. In some cases however, the necessary information to show that appropriate checks of people's employment history was not in place. We saw that a number of staff had been responsible for gathering recruitment information which meant that no one had assumed responsibility for ensuring the correct processes had been followed.

People told us that they were happy with the care they received and said that they felt well looked after. One person told us that they had noticed definite improvements since the last inspection, in particular that there were more staff around to support them. A relative also told us "There are more staff about."

Staff told us that "Things are much better" and said that the interim manager provided very clear leadership and direction. Staff said that the new staffing structure enabled them to provide better care to people because they had more time to spend with them. We saw that staff were better engaged with people at this inspection and encouraging them to participate in activities that were meaningful to them.

We read that where risks had been identified in respect of people's hydration, weight or skin integrity, appropriate monitoring systems had been put in place. For example one person was receiving end of life care and steps had been taken to ensure she remained as comfortable and pain free as possible.

People were protected from harm because staff had a clear understanding about their roles and responsibilities in relation to safeguarding. People told us that they felt "Safe" at Linwood. Staff were able to describe what they would do if they ever had any concerns about abuse.

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

The service was not always safe.

Medication Administration Records (MAR) did not always reflect the medicines prescribed and administered.

Recruitment records did not always show that appropriate employment checks had been followed prior to new staff commencing work.

Staffing levels were now sufficient to meet people's assessed needs.

People were safeguarded from abuse because staff understood their roles and responsibilities in protecting people from abuse.

People were kept safe because risks were identified and mitigated.

Is the service well-led?

Requires improvement

There were still some inconsistencies between the leadership of the interim manager and the day to day monitoring of care practices.

Gaps in record keeping meant that required information was not always easily accessible.

The provider and interim manager had a good overview of the home and clear plans as to how necessary improvements would be made.

The culture of the home was open and people and their relatives were kept informed and involved in the changes taking place.

The provider was now communicating effectively with the Commission.

Linwood

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 was a focussed inspection to look at whether the service had complied with the Warning Notices issued following our last inspection. Due to the seriousness of our concerns at the previous inspection, we re-inspected our key questions of Safe and Well Led.

This inspection took place on 28 September and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because this was a focussed inspection in which we were only looking at specific areas.

As part of our inspection we spoke with 13 people who lived at the home, three relatives, eight staff, the interim manager and two other health and social care professionals. We also reviewed a variety of documents which included the care plans for 18 people, eight staff files, medicines records and various other documentation relevant to the management of the home. Some records were held centrally and as such we also visited the provider's main office as part of the inspection.

The home was last inspected in June 2015 when we rated the service Inadequate overall and the provider was placed in Special Measures.

Requires improvement

Is the service safe?

Our findings

Both people and their relatives described Linwood as a safe place to be and said that they had never experienced any ill-treatment or loss of property. People consistently told us "I feel very safe" and "yes, I have definitely felt safe here."

People said that they received their medicines when they expected them each day. We did however identify that Medication Administration Records (MAR charts) were not always reflective of the medicines that had been prescribed and administered. For example some medicines had been given and not appropriately signed for. One staff member told us that they had forgotten to sign for a medicine that they had administered the previous day. Another staff member had signed in the wrong place. As such, the MAR charts were not always an accurate reflection of the medicines that had been given.

We also found that where prescribed medicines had been stopped or changed by a doctor, this information had not always been reflected on the MAR chart. In two cases we saw that people getting the right dose of their medicines was based on staff knowledge and memory rather than the availability accurate information.

Failing to have systems to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that medicines were stored securely and only staff who had received training in the safe handling of medicines were permitted to administer medicines to people. Each person had their own MAR which contained a photograph of them and details of any allergies. Where people were prescribed occasional medicines, such as a pain relief, there were guidelines in place which explained when this should be administered and in which dose.

People were not adequately protected as the recruitment system in place at Linwood was not robust. From the information available, it was not possible to evidence that appropriate employment checks had been followed prior to new staff commencing work. For example, we found that gaps in the employment histories for four staff members had not been explored. Similarly, steps had not always been taken to ensure appropriate references for staff had been obtained. In particular, where people had previously worked in care, references had not always been obtained from their past employers. This information is crucial in order to make judgements about a potential staff member's suitability to work with people whose situation makes them vulnerable.

Failing to have effective recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite some gaps in record keeping, we saw that risks to people's health and safety were better managed than previously. For example we found that where people had been assessed as being at risk of pressure wounds or dehydration, systems had been put in place to monitor this and maintain people's wellbeing. We saw that one person was receiving end of life care and staff were taking appropriate action to mitigate associated risks and keep them as comfortable and pain free as possible. For another person who had experienced multiple falls we read that their risk assessment had been recently updated to reflect the increased risk. Appropriate actions had also been taken to reduce the risk including referrals made to the falls team and social services. The falls team is an external team which provides specialist support to people at risk of falls.

There were now sufficient staff to meet people's assessed needs. The provider and interim manager told us that they had conducted a review of staffing levels and as such had increased the number of staff working in the home. There was now a minimum of 10 care staff and three team leaders throughout the day. On many shifts there were 11 care staff and the interim manager said this was the level they were working towards. We found that the increase in staff had improved the way people were supported. We saw that people were better engaged because staff had more time to spend with them. Increased staffing levels also meant that people could follow their own routines. One person said "I am able to have my breakfast late now" and another said "I feel I have the freedom to be where I want and to ask for help."

Staff echoed the benefits of having more staff and said that staff sickness and absences were always covered now. They also told us that the change to having a team leader working on each of the three floors had made a positive difference to the way they worked. Care staff said this meant that they could get on and provide the care they needed to and know that other issues were being dealt

Requires improvement

Is the service safe?

with. Staff told us that they felt happier at work now because "They now had time to spend with people." We observed that staff were talking with people and engaging them in activities throughout the day.

People were protected from abuse. The home had clear policies and procedures in respect of safeguarding people, with a flow chart of who staff should contact if they suspected abuse. We read in staff meeting minutes that staff roles and responsibilities in relation to safeguarding had recently been explained to them. All staff spoken with were confident about the types of abuse and who they needed to report to if they had any concerns. A review of the records in relation to safeguarding showed that any concerns were handled quickly and appropriately.

Requires improvement

Is the service well-led?

Our findings

Most people told us that they thought the home was well managed. People felt that there was now a management presence in the home and made comments such as "The [interim] manager is very helpful and knowledgeable" and "The [interim] manager is always present." People said that they had confidence that when they raised issues they would be sorted out. For example one person said that they had complained that staff did not always wear name badges and this had now been rectified. A relative told us "We are all happy she [the interim manager] is here."

It was evident that the interim manager had a good understanding of the issues in the home and the work that still needed to be done. Gaps in daily record keeping however showed that there were some inconsistencies between the leadership of the interim manager and the monitoring of day to day care practices. The management structure within the home was not always being used effectively to make the improvements highlighted by the provider and interim manager. For example, daily audits of MAR charts had not always identified gaps in staff signing for medicines that they had given. Similarly, a chart introduced to check the setting of a person's pressure mattress each day had not been completed for two days and no one had checked this.

The interim manager explained how care plans were in the process of being reviewed as were the significant gaps in the way information was recorded. In some cases details had been included, but not in a way that was accessible or useful. For example, the nutritional care plan for one person did not make reference to the guidelines from the Speech and Language Therapist (SLT) which meant that staff needed to refer to two separate documents in order to read how to support the person to eat. Similarly, when staff had made referrals to other professionals, such as a doctor or district nurse, the outcome of these referrals had not always been documented.

The failure to maintain accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture of the home was open and people, their relatives and staff were kept informed and involved in the changes taking place. We read in meeting minutes that the provider had shared the outcome of our last inspection with all parties and been transparent about the improvements that needed to be made. People said that they had been asked to give their feedback and that there had been lots of discussion about what things they would like to see improve. People said they had felt that they were being listened to and that the home was changing for the better.

Staff told us that the interim manager was very visible in the home and that there was a greater sense of leadership and direction. Staff said the interim manager had joined them at their daily handovers and felt that she was "On top of issues." Several staff commented that they were clear what was expected of them and also had confidence that the things they raised were now being addressed. We found that morale was good in the home and staff said this was because there were more staff and they were working better together as a team.

Since the last inspection the provider has communicated more effectively with the Commission. For example, at our last inspection we identified that the Registered Manager had not notified us of incidents and events at the home in accordance with their legal duty to do so. Since then we have noticed an improvement in the submission of the required notifications which are now received in a timely way. The provider has also submitted clear action plans about the improvements they have identified and how and when these will be made. We have found these to be an accurate reflection of the situation within the home.

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	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not always ensured the proper and safe management of medicines because Medication Administration Records were not accurately maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person failed to have effective recruitment procedures in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person failed to maintain accurate, complete and contemporaneous records.**