Goring Care Homes Limited

Lyndhurst Residential Care Home

Inspection report

Lyndhurst Road
Goring-on-Thames
Oxfordshire
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Date of inspection visit: 24 September 2015
Date of publication: 23/10/2015

Ratings

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

Overall summary

We carried out our inspection on 24 September 2015. This was an unannounced inspection.

The service had a registered manager who was responsible for overall management of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated regulations about how the service is run.

Summary of findings

Lyndhurst Residential Care Home is a care home providing accommodation and personal care for up to 20 people. The home supports people living with dementia. At the time of our visit there were 14 people living at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS enable restrictions to be used in a person's support, where they are in the best interests of a person who lacks capacity to make the decision themselves. The registered manager had made appropriate referrals to the supervisory body. However, where people lacked capacity to make decisions the registered manager was not acting within the principles of the Mental Capacity Act (2005).

People were positive about living in the home and were complimentary about the registered manager and staff. The atmosphere in the home was cheerful and relaxed. We saw many kind and caring interactions where people were laughing and smiling with staff. Staff felt supported and knew people well.

The registered manager was approachable. People and staff were complimentary about the registered manager.

People did not always have access to activities that interested them and told us they did not have many opportunities to go out of the home. Some people who remained in their rooms spent long periods without social interaction.

Medicines were not always managed safely. Staff were not always clear about the policies and procedures associated with administration of medicines.

The systems in place to monitor the quality of service were not always effective as there were no action plans to identify what action was being taken as a result of surveys and audits.

The home provided support for people living with dementia. We have made a recommendation about dementia friendly environments.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the end of the full version of the 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?
The service was not always safe.

People's medicines were not always managed safely.

Staff understood their responsibilities to identify and report any concerns relating to the abuse of vulnerable people.

There were sufficient staff to meet people's needs

Requires improvement

Is the service effective?
The service was not always effective.

Where people lacked capacity to make decisions the provider was not always working to the principles of the Mental Capacity Act (2005). People's rights were not always upheld.

Staff received support and had access to development opportunities.

Food and drink provided was sufficient to meet people's needs.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with dignity and respect.

People were supported by staff who were kind and caring and treated them as individuals.

People were involved in decisions relating to their care and felt they were listened to.

Good

Is the service responsive?
The service was not always responsive.

People did not always have access to activities that interested them.

People's care plans were personalised and contained information that enabled staff to meet their needs.

People knew how to make a complaint and were confident they would be listened to.

Requires improvement

Is the service well-led?
The service was not always well led.

There was no system to monitor trends and patterns in relation to accidents

and incidents. Quality assurance systems were not always effective.

There was a caring culture in the home, where everyone felt valued.

Requires improvement

Summary of findings

The manager was approachable. People, relatives and staff were comfortable speaking with the manager about any issues.	

Lyndhurst 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 24 September 2015 and was unannounced. At the time of our visit there were 14 people using the service. The inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of

using or caring for someone who uses this type of care service.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). 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.

During our inspection we carried out 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. We also observed care practices throughout the day.

We spoke to nine people who used the service, six visitors and two visiting health professionals. We looked at three people's care records, three staff files and other records showing how the home was managed. We spoke to the registered manager, the deputy manager, two team leaders and three care workers.

Requires improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. Systems to ensure people were receiving their medicines as prescribed were not always effective. For example, it was not possible to monitor the balances of medicines not in a monitored dosage system (MDS) as there were no balances carried forward on the medicine administration record (MAR).

MAR did not always contain information relating to specific instructions about the administration of medicines. For example, one person was prescribed a medicine that required them to remain in a specific position after taking the medicine. This information was not recorded on the MAR. Staff we spoke with, who were responsible for the administration of medicines, were not aware of the specific requirements related to the administration of this medicine. There were patient information leaflets provided by the pharmacy for all medicines administered in the home. These were kept in a separate file away from the MAR.

Medicines not in the MDS did not always have the date of opening recorded. For example, one person was prescribed a liquid medicine that required it to be discarded 28 days after opening. No date of when the medicine was opened was recorded. It was not possible to monitor whether the medicine had been opened for longer than required.

Topical medicines were kept in people's rooms and were administered by care staff. Topical medicines are medicines that are applied to body surfaces, for example creams and ointments. Records relating to the administration of topical medicines did not always contain all the information relating to the administration of the medicine. Records were not always completed. We could not be sure people were receiving their topical medicines as prescribed

The provider did not have a policy or procedures for the reporting of medicine errors. Staff responsible for the administration of medicines told us they had never experienced a medicines error; however they told us they would look for the policy if it happened.

We spoke to the manager about these issues who told us they would take immediate action to address them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt safe living in the home. Comments included: "Oh yes, definitely feel safe here"; "Yes I feel safe living here, I like it, I am well looked after"; I feel safe here. I used to fall a lot when I lived at home there is always someone about here" and "I feel safe here, there are people around all the time".

Visitors we spoke with told us people were safe. One relative told us, "I definitely feel my [relative] is safe here and [relative] has been here for five years. My [relative] is so happy here and she is always smiling. I would know if she was unhappy".

Staff understood their responsibilities to report any concerns regarding abuse and knew where to report outside of the organisation. Staff were confident that any concerns would be taken seriously and managed in a timely manner.

People, relatives and staff told us there were enough staff to meet people's needs. One person said, "I think there are plenty of staff, they (staff) pop in all the time". Staff told us they had time to sit and talk with people and that staffing levels had, "Really improved".

During the inspection the atmosphere was calm. Staff were not rushed and people's requests for help or support were responded to promptly. Call bells were answered in a timely manner.

People's care plans contained risk assessments which included: falls; choking, nutrition, pressure damage. Where risks were assessed care plans contained risk management plans. For example, one person was at risk of choking. The care plan identified the support the person needed when eating and the options the person should be given to reduce the risk of choking and to maintain their dignity. We saw staff supporting the person in line with their care plan.

During our inspection the home's lift was out of order. Appropriate action had been taken to maintain people's safety. For example, two people were unable to manage the stairs and a communal lounge had been created in an empty room to reduce the risk of social isolation. People and where appropriate their relatives, had been offered alternative accommodation in another care home owned by the provider.

Requires improvement

Is the service effective?

Our findings

Staff did not always have a clear understanding of the Mental Capacity Act (MCA). The MCA is a framework to ensure, where people lack the capacity to make decisions, any decisions made on the person's behalf are made in their best Interest. Not all staff we spoke with had received training in MCA. Training records showed that not all staff had completed training in the MCA.

People's care plans did not always contain clear information about the person's capacity. For example, one person's care plan contained a capacity assessment which identified the person had capacity to make decisions relating to personal care. However the care plan contained instructions from a relative detailing what personal care the person should receive.

One person we spoke with told us they did not like having bed rails. We looked at this person's care plan and saw that a best interest process had been followed which included discussion with a relative and health professional regarding the use of bed rails. There was no capacity assessment relating to the decision to use bed rails and no record showing the person had been spoken to in relation to this decision.

Some people's records indicated that a lasting power of attorney (LPA) had been appointed. A lasting power of attorney is a legal document that lets a person appoint one or more people to help them make decisions or make decisions on their behalf. However, for one person there was no copy of the LPA and the registered manager told us they had not seen a copy. The registered manager was unclear whether there was an LPA for health and welfare. However, the person's care plan contained several decisions made by a relative who had told the home they had a LPA.

These issues are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People told us they were supported by staff who had the skills and knowledge to meet their needs. One person said, "The staff understand me".

Care staff we spoke with were knowledgeable about people's needs and were able to tell us in detail how they supported people. For example, all care workers we spoke with were able to tell us about the dietary requirements of one person who required some foods to be pureed.

Care staff told us they were well supported by the registered manager and deputy manager. Support included regular supervisions (one to one meetings with their line manager) and appraisals. Care staff told us supervisions were useful and enabled them to reflect on what had gone well and what had not gone so well. Care staff were encouraged to identify development activities. For example, one member of the care team wanted to develop as a trainer. The registered manager was supporting this.

New staff completed an induction programme. One new member of the care team told us they had attended training and completed workbooks as part of their induction. The induction training included; safeguarding, moving and handling, diabetes, first aid and infection control.

Care staff had access to national qualifications and some staff we spoke with had completed their level 2 and level 3 qualifications in health and social care.

People were complimentary about the food. Comments included: "The food here is lovely, there is plenty to eat and drink"; "The food here is so good I was getting fat. There is one main but we get a choice of three puddings" and "We have very nice food here; I eat everything that is put in front of me".

People told us there was only one main course available. If they did not like the main course they could request an alternative meal. One person said, "I have plenty to eat and drink, you can choose a dessert but not the main, If I don't like it they are very obliging and make me something else".

Relatives were also positive about the food in the home. One relative said, "My [relative] has plenty to eat and [relative] loves her food".

The atmosphere during lunch was calm and cheerful. People were supported to sit where they chose to eat their meal. People who preferred to eat in their rooms were supported to do so. Food looked appetising and everyone enjoyed their meal. People who required support to eat their meal were supported in a respectful manner.

Requires improvement

Is the service effective?

People's care plans contained details of individual dietary requirements. For example, one person could become anxious when eating with other people and preferred to eat at a different time. The care plan contained information detailing how the person's needs would be met. We saw care staff support the person to spend the mealtime in the garden and was provided with a meal later in the day.

People at risk of weight loss had their food and fluid intake monitored. At the time of our inspection no-one was identified as at risk of weight loss. People who had been at risk of weight loss had been referred to appropriate health professionals and had been provided with a fortified diet.

People had access to a range of health and social care professionals. Care plans contained details of people having access to G.P's, chiropodist, Care Home Support Service (CHSS), district nurses, dentists and opticians. People told us they had access to their GP. One person said "I can see a doctor when I want". One person told us they needed to see an optician. We spoke to the registered manager who told us the person had recently seen an optician and had glasses as a result. We saw details of the opticians visit in the person's' care plan.

Health and social care professionals visiting the home on the day of our inspection told us staff made appropriate referrals to services in a timely manner.

The home was clean and bright. People had access to an enclosed garden and we saw people going in and out to the garden throughout the day. The home supported people living with dementia; however the environment was not always dementia friendly. For example, people's rooms were identified with names and numbers. However there was no meaningful symbols or pictures to support people living with dementia to recognise their rooms. Tablecloths and crockery were white, making it difficult for people with dementia to distinguish between the table and their plate.

We recommend the service seeks advice and guidance from a reputable source, about dementia friendly environments.

Good

Is the service caring?

Our findings

People told us staff were caring. Comments included: “Oh the staff are definitely caring, they are caring to me anyway, they don’t rush me”; “The staff we have got here are very caring, they never rush me and are very patient”; “The staff are caring and very kind and thoughtful” and “We are not just a number here, we are treated properly like people”.

Relatives were complimentary about the care provided in the home. One relative told us, “The staff are very caring. They often give residents a little hug and the residents love to be touched”.

Staff had a caring attitude. One member of staff told us, “They [people living in the home] are like my family, so I want what’s best for them. We [staff] all want what’s best for them”.

There was a caring culture in the home and staff spoke with people in a kind and respectful manner. Throughout the day there was a positive, cheerful atmosphere. Staff chatted and laughed with people.

We saw many kind and caring interactions. Staff explained what was going to happen before supporting people. For example, one person needed the support of two carers to transfer from their wheelchair into a chair. One care worker made sure they were in a position that enabled them to make eye contact with the person and explained what was going to happen. The care worker confirmed the person was happy to move and the person smiled and nodded. Throughout the support staff explained in detail what was happening and praised and encouraged the person. When the person was in the chair one care worker checked they were comfortable. The care worker gently touched the person’s hand to reassure.

People were treated with dignity and respect and encouraged to maintain their independence. Comments included: “I am respected and treated with dignity”; “The staff never rush me. They help me with my food and try to keep me independent” and “They always knock on the door and close the curtains before doing my care”. When staff were speaking with people they referred to them using the person’s preferred name.

People were involved in decisions about their care. One person told us, “The staff listen to me and if they are changing my care we talk about it”. Relatives were also involved in decisions where appropriate and told us they were invited to care reviews. One relative told us, “The staff have case meetings with me and keep me up to date”.

Requires improvement

Is the service responsive?

Our findings

People enjoyed living at Lyndhurst. People told us they were able to spend their day as they chose, however some people told us they would like to go out more and that there was not much to do in the home. Comments included: "I can do anything I want really, but I have to sit around, there is not much to do" and "I never go out in the community, I would like to do that".

Some people who remained in their rooms spent long periods of time without any visits from staff. One person told us, "No-one stops to chat". The person's care plan identified the person 'liked to chat'. However, we saw one person had many visits from staff. We saw staff looking at photographs with the person and spent long periods of time chatting and laughing with them.

The service did not employ an activity co-ordinator. The registered manager told us this was the responsibility of all staff. Staff told us if they had time activities usually took place in the afternoon.

There was a board displaying weekly activities. Staff told us the board was not up to date. Staff were unsure what and when activities took place. During the afternoon of our visit, staff engaged people in the lounge area in a game. People enjoyed the game and were chatting together.

Staff we spoke with told us they took people out for a walk sometimes. One member of staff told us, "There isn't much opportunity to go out, but we take people when we go on errands".

People who were able to walk independently could walk freely into the garden. We saw some people doing this. Although staff were not rushed, we did not see staff support anyone to go out in the garden during our visit.

People from the local community visited the home. This included a Pets as therapy (PAT) dog, a local singing group and the priest from the local church. The volunteer and PAT dog visited on the day of our inspection. People enjoyed the visit and spent time stroking the dog and talking to the volunteer. The volunteer told us that if people in their rooms wished to see the dog, the volunteer would visit.

People were assessed before they moved into the home. The information was used to complete a care plan which detailed the support the person needed. Care plans contained a 'knowing me' document which included information about people's past, their likes and dislikes and how they wanted to spend their time. One person's care plan identified they could become anxious and needed reassurance. The person's care plan also identified the person liked toffees. We saw staff support the person when they became anxious in a calm and supportive manner and staff suggested to the person that they may like to get a toffee.

People told us they knew how to complain and would be happy to do so. However no-one we spoke with had ever had to complain. Comments included: "I know how to complain but I have never had to"; "If I had a complaint I would go straight to the manager, I have never had to" and "I would just tell the staff if I was not happy. I have never had to complain yet".

Relatives knew how to complain. One relative told us, "I have never had to complain. I would complain to the manager".

People and their relatives told us they were not aware of any meetings for them to share their experience. We spoke to the registered manager who said people in the home had not wanted meetings. The registered manager told us people and their relatives were able to speak with them at any time to discuss issues or concerns. Complaints received were dealt with in line with the provider's complaints policy.

The provider had completed a survey for relatives in 2013 and that a survey for 2015 was just being planned. However, there was no evidence of any action being taken as a result of the survey.

Requires improvement

Is the service well-led?

Our findings

Accidents and incidents were recorded, which included details of any injury. However there was no record of what actions were taken as a result of the accident/incident or of any actions to reduce the risk of it happening again. There was no system in place to monitor accidents and incidents to enable improvements to the quality of the service.

The service carried out a range of audits. These included infection control, housekeeping, kitchen, dining experience and first impressions audits. Where issues had been identified it was not always clear what action was being taken as a result and by whom. Where actions had been identified there was no system in place to monitor the progress of actions.

The service had carried out a dignity audit and staff satisfaction survey with all staff. There was no action plan of either activity to identify how the quality of service would be improved as a result. We spoke with the registered manager who told us no action had been taken as a result of the dignity audit or staff satisfaction survey.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People and their relatives were complimentary about the registered manager. One relative told us, "I know the manager, this service is well-led. It is a home from home for me. I can't think of anything they could do better".

People chatted with the registered manager throughout the day and the manager knew everyone well. The registered manager spent much of the day in the home and we saw they promoted a caring and supportive approach to people, relatives and staff.

Staff were complimentary about the registered manager and were positive about working in the home. Comments included: "[The registered manager] and [deputy manager] are very good. They are good professional people"; "I like [registered manager], we get on well. They [registered manager] are very approachable and I can knock on the door and have a chat at any time"; "I get on really well with [registered manager]. Very supportive and I can talk to them about anything" and "I am well supported and in general the home runs well".

Staff were comfortable to raise any concerns with the registered manager and knew about the whistleblowing policy. Staff were positive that their concerns would be taken seriously and action would be taken promptly.

There were regular staff meetings and staff told us they found the meetings useful and felt listened to. For example, one member of staff had made a suggestion about a change to the rota to improve the staff cover. This had been trialled and had now been permanently implemented. One member of staff told us they had been encouraged to experience how staff behaviour could impact on people. The member of staff had sat in a wheelchair during a staff meeting and been assisted to eat by a member of the care team. The member of staff told us the positive impact this had on staff practice when they shared their feelings of the experience.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure care was provided in a safe way as they had not taken appropriate action to mitigate the risks associated with the safe management of medicines. Regulation 12 (1) (2) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure that care and treatment was only provided with consent from the relevant person. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. The provider did not have effective systems in place to seek and act on feedback from relevant people. Regulation 17 (1) (2) (a) (e)