Forest Residential Care Homes Limited

Lyncroft

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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**

Summary of findings

Overall summary

This inspection took place on 15 August 2018 and was announced. The service was last inspected in June 2016 when it was rated requires improvement in safe, good in effective, responsive, caring and well-led.

Lyncroft is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lyncroft is a care home for adults with mental health needs. It accommodates up to 12 people and 11 people were living there when we completed our inspection. It is a large house in a quiet residential area in east London. Each person has their own bedroom with shared bathroom, cooking, dining and living spaces. There is a separate building in the garden used as an activities centre by people living in all the provider's homes.

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 provider applied to have their registration amended during the inspection.

Care plans and risk assessments did not contain enough information to ensure people received personalised support that ensured their needs were met and preferences were respected. Reviews did not lead to changes in people's goals, and goals were not always appropriately set or monitored. There was not enough information about people's health care needs or the involvement of other professionals to ensure people received effective, coordinated care. People's views about end of life care had not been established. Medicines were not managed in a safe way and other risks had not been appropriately mitigated. The home was not clean and there was a strong malodour in one of the bathrooms.

Staff had been recruited in a way that ensured they were suitable to work in a care setting. However, they worked excessive hours. Staff told us they received training relevant to their roles. Staff supported people to attend health appointments as needed. People were supported to attend their places of worship and went to the activities centre located in the garden. The structure and purpose of activities was not clear.

The audit and quality assurance systems were not operating effectively to identify and address issues with the quality and safety of the service. The provider had told us they would update care files and risk assessments but had not done so to an appropriate standard. The systems for analysing and responding to incidents were not robust. The provider had not submitted notifications as required.

People told us they liked the food, and we saw a varied menu was on offer. Staff did not always treat people with respect although their privacy was upheld. The impact of people's cultural background, religious beliefs, sexual and gender identity was not always considered. We have made a recommendation about ensuring care is planned to respect diverse characteristics.

Staff knew people well and knew the details of people's support needs; their knowledge was not reflected in the paperwork. People told us they liked the staff and would tell them if they had any concerns. Staff were knowledgeable about safeguarding adults from harm and abuse. People knew how to make complaints. No complaints had been made.

There were regular meetings for staff and people who lived in the home. However, opportunities for people and staff to contribute to the development of the service were limited.

We found breaches of six regulations regarding person centred care, safe care and treatment, premises and equipment, good governance, staffing and notifications of incidents. Full details of our regulatory response is added to reports after all representations and appeals have been exhausted.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not managed in a safe way as staff did not have clear guidance in place to ensure they knew how to support people with their medicines.

Risks were not appropriately mitigated as guidance was limited.

The home was dirty and this meant risks of infection were not controlled.

Staff were working excessive hours.

The systems for ensuring lessons were learnt from incidents were not robust.

Staff knew how to identify and respond to allegations of abuse.

Is the service effective?

Requires Improvement

The service was not always effective. People's care plans lacked detail and it was not clear what support they needed to achieve their goals.

Staff told us they received training, but records had not been appropriately maintained.

The provider was not able to demonstrate how they worked in partnership with other organisations to ensure people received effective care.

People were supported to access healthcare services when needed, but the information about people's healthcare needs was limited.

The service had applied for appropriate authorisations to deprive people of their liberty under the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring. Staff did not always behave in way that demonstrated they respected people.

People were supported to attend their places of worship, but their religious and cultural needs were not considered within the care plans.

People's sexual and gender identity was not considered as part of their assessments or care plans.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not personalised and were not updated or reviewed to ensure they were up to date.

Activities lacked structure and purpose.

People had not been asked about their views about end of life care.

People knew how to make complaints, but opportunities for feedback were limited.

Is the service well-led?

Requires Improvement

The service was not always well led. Systems and processes had not operated effective to ensure the quality and safety of the service.

The provider had not stayed up to date with best practice.

People and staff completed surveys about their experiences.

People and staff told us they could approach the provider if they needed to.

Lyncroft

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 15 August 2018 and was announced. The provider was given 48 hours' notice as the home supports younger adults who are often out during the day; we needed to be sure people would be in.

The inspection was completed by one inspector and one assistant inspector.

Before the inspection we requested feedback from the local authority where the service is located. The provider was not asked to complete a provider information return.This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we already held about the service in the form of feedback and notifications. Notifications are information about events and incidents providers are required to tell us about by law.

During the inspection we spoke with three people who used the service and five staff including the nominated individual, the training manager and three support workers. We reviewed three people's care files including needs assessments, risks assessments, care plans and records of care. We reviewed three staff files including recruitment, training and supervision records. We also reviewed various documents, policies, records and audits relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

We had made a recommendation in June 2016 for the provider to seek and follow best practice guidance for managing medicines in care homes. This was because the systems for auditing and controlling stock of medicines were not robust. Although the provider now had effective stock monitoring systems in place, they had not followed this recommendation as the information about medicines within the home was not in line with best practice guidance.

In June 2016 the provider told us they would update information about people's medicines. This was because there were no individual guidelines in place for medicines prescribed on an 'as needed' (PRN) basis. The information in place had not been appropriately updated and remained insufficient to provide clear guidance for staff.

For example, one person had a list of relapse indicators for staff which was vague and did not describe the intensity or frequency which would indicate concern. Staff were instructed to offer 1:1 support, refreshments, music and contact with their family. The plan then stated, "If all these fail speak to manager to initiate PRN protocol. Manager will assess and give instruction whether PRN medication is required. Follow PRN mediation protocol. Administer PRN medication as instructed." This was not clear about the de-escalation techniques or indicators that PRN medicines should be administered. In addition, this person had been prescribed paracetamol for pain relief as needed but there was no guidance in place to inform staff when to offer or administer this. Records showed this person expressed they had pain, but were given their psychiatric medicine ahead of pain relief.

After the inspection the provider submitted amended PRN protocols. However, these remained insufficient. For example, one person was prescribed two different pain relieving medicines on a PRN basis. The signs and symptoms were identical on both guidelines, stating that the person would be complaining of pain in specific areas of their body. The guidance on both then stated, "As it is for occasional use, should be offered the medication at the times they are experiencing the signs and symptoms either by telling a member of staff or by staff assessment and identifying the residents' needs. Contact the manager. Then PRN medication will only be given after discussion, consultation and on the strict instructions of the manager." There was no contingency should the manager be unwell or unavailable. This meant there was a risk this person may be over medicated, or under-medicated when the manager was unavailable to authorise the administration of pain relieving medicines.

Another person had been prescribed a sedative medication on an 'as needed' basis. There was no guidance within their file about when to offer or administer this medicine. Records showed this person had been given this medicine in response to an incident where they had stolen cigarettes and smoked them in the toilet contrary to the house rules and smoking policy. The description of the incident did not describe any violent, aggressive or agitated behaviours but stated, "[Nominated individual] informed and [medicine] given with good effect."

Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being

misused, being obtained illegally or causing harm. We asked the provider if anyone living in the home was prescribed controlled drugs and they told us they were not. However this as not the case as one person had been prescribed tramadol. Tramadol is a controlled drug, but is exempt from safe custody arrangements. The provider was not aware that of this.

Furthermore, no one in the home had an individual medicines care plan. There was no information within care files about the purpose, side effects or possible contra-indications of medicines people had been prescribed. Information about medicines within care files was not clear. For example, the list of medicines on one person's emergency information did not include full dosage information and did not match the list of medicines in the GP information or the medicine administration record. After the inspection the provider told us they completed emergency information sheets during emergencies. The information in the file was historic and should have been removed. Another person's care file stated they took three medicines, however their medicine administration record contained an additional four medicines, and the dosages did not match.

One person's medical records showed they had a drug allergy, however their medicine administration record stated "none known" regarding drug allergies. This meant there was a risk they may be prescribed a medicine they were allergic to as this information was not clearly recorded or available to staff.

After the inspection the provider submitted medicines plans in response to our feedback. However, these remained insufficient. The dosage and timing information was not included. Some medicines can be prescribed for more than one reason. For example, the same medicine may be used to treat seizures and mood disorders. The purpose was not included in the updated medicines care plan which were submitted. It was not clear if people were prescribed medicines due to seizures or to treat a mood disorder.

In June 2016 the provider told us they would update risk assessments as the ones in place had lacked detail. They had failed to do this, and risks had not been appropriately identified or mitigated. For example, one person was identified as being at risk of financial exploitation but there was no risk assessment in place to mitigate this. The provider told us this risk was only present when the person lived in the community and was no longer current. However, this was not clear from the records.

Where risk assessments had been written they did not provide sufficient information to enable staff to mitigate risks. For example, for the risk of assault the measures in place were, "Key worker / staff team be vigilant, 1:1 with [person] set boundaries on socially acceptable behaviour. Staff to maintain and reinforce set boundaries. Telephone police 999 if necessary." There was no guidance about what boundaries on socially acceptable behaviour were, or how to reinforce these. Another person had a risk assessment in place about physical assault which stated, "Placate him with cigarettes." Records showed this person had stopped smoking in May 2018 which meant these measures were not appropriate. This person was identified as being at risk of absconding, however, their missing person profile had not been completed and did not contain information on their build, characteristics or risk factors. Another person's missing person profile described their hair as "fair" when we saw it was dark brown and the profile had not been updated for over two years. After the inspection the provider told us missing person's information was completed after the person went missing.

After the inspection the provider submitted amended risk assessments. These did not contain specific information about how to mitigate risk. The measures described above, and explained to the provider as being insufficient had not been amended and there was no further details of how staff should mitigate risks.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

There were communal bathrooms in the home, with an accessible shower and separate toilet on the ground floor, and a separate toilet and bathroom upstairs. We found the bathrooms were not clean or well maintained and posed an infection control risk to people living in the home. In particular, the upstairs toilet had a very strong urine smell, and water damage around and below the sink. The door caught on the radiator preventing it from opening easily, the light switch cord was snapped and beyond reach and the carpet flooring did not reach the edges of the toilet with floorboards being visible at the edges. The nominated individual told us the smell was due to the behaviour of one person who lived in the home and had only got into this state on the day of the inspection. The ingrained nature of the smell, and the damage to the floor and under sink area meant this was not the result of one day's behaviour. The nominated individual completed monthly audits which each stated "all satisfactory" in relation to hygiene control and infection.

The plug cover in the downstairs shower was missing which created both a health and safety and infection control risk. The nominated individual told us one person repeatedly took out the plug hole cover and threw it away. They told us they were constantly buying new covers and getting them installed, however, this was not recorded in the maintenance log. The nominated individual told us they did not record it in the maintenance log as they fixed it so often. In addition, the shower rail in the upstairs bathroom was broken, and two of the four toilet seats needed repair to make them safe during the inspection. In the garden there was a picnic bench with four seats attached, one of these seats was broken and unsafe but there was no signage advising people not to sit on it. The back area of the garden was overgrown and contained a cement mixer, old garden furniture and two upturned wheelbarrows. We saw people accessed the garden throughout the inspection but there had been no action to address the poorly maintained end of the garden. An incident report showed that one person had absconded by climbing over the garden fence and the lack of care taken with the garden meant this would still be possible. After the inspection the provider told us they had made improvements to the garden following our feedback.

The above issues are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider submitted photographs to show redecoration and repair had been carried out in the toilet and bathroom. The provider also submitted a diary page entry that showed they had scheduled redecoration of the bathrooms for August 2018. However, this had not considered the need for immediate action regarding the condition of the toilets.

Recruitment records showed the provider completed checks on staff to ensure they were suitable to work in a care setting. This included checks on their character via references and completion of a criminal records check as well as checks of their identity and right to work in the UK.

The rota showed staff were scheduled to work excessive hours. One member of staff regularly worked a day shift from 8am to 8pm immediately followed by a night shift from 8pm to 8am. This meant this staff member was on duty for 24 hours. We had previously discussed this with the provider after we had received a whistleblowing alleging unsafe staffing. The provider told us staff received an additional hour long break when working a 24 hour waking shift. The provider also said a 24 hour shift was possible as the night shift duties were "very light" and "They do sleep. They do the two hourly checks. They do sleep." The rota showed both a waking night and sleep-in each night and the service commissioned was a waking night service. As people required a waking-night support there was a risk that staff asleep on duty due to excessively long shifts may not respond to people's needs appropriately. Records showed that people did not always sleep

all night, and some people engaged in risky behaviours including smoking during the night. This meant that if staff were asleep and unable to monitor people's behaviour the risks of fire were not appropriately mitigated.

The above issues are a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective systems for recording or responding to incidents. This had been identified in a local authority contract monitoring visit completed in April 2017 but had not been addressed by the provider. We asked the provider for their incident records and were given an accident book but found this did not contain records of incident referred to in people's care records. The provider told us incidents were recorded in daily logs, or in ABC charts. ABC charts are a way of recording behaviours which can be risky to people and others; they consider the antecedent, what was happening before the behaviour, the behaviour itself and the consequence. Recording incidents using ABC charts can provide information for analysis of themes of incidents.

The provider was not using ABC charts in this way and there was no follow up analysis or review following incidents recorded in ABC charts. Where incidents occurred, the only analysis found was in a monthly summary sheet and each of these stated there was no changes to care plans or risk assessments even when incidents had occurred.

There had been no incidents which constituted allegations of abuse. Staff were knowledgeable about the different types of abuse people might be vulnerable to and knew what action to take if people made allegations they had been abused. Staff knew how to escalate concerns to the local authority if they were not satisfied with the response of the home.

Requires Improvement

Is the service effective?

Our findings

People told us they had goals and ambitions for the future. However, these were not clearly captured in their care plans and the support people needed to achieve their goals was not described. For example, one person's goal since 2013 had been recorded as being their wish to move to a more independent setting. There was no specific plan in place to support them to achieve this goal, and this person was also subject to restrictions which meant moving to a different address would not be possible without the agreement of the Ministry of Justice. This meant the goal was inappropriate and unfair as the person will not be able to achieve it.

People had care plans in place for different aspects of care. However, they did not contain enough information to inform staff how to provide the support people needed. For example, one person's care plan in relation to personal care stated, "Needs constant verbal prompting, support, guidance and assistance from staff on all self-care tasks, personal hygiene, shaving, washing, dressing, eating etc. incontinent of urine, will remain in soiled clothes, bedding. [Person] is at substantial risk of serious abuse or self neglect without constant staff invention." The support, guidance, assistance and interventions were not described.

Another person's overall goal of support was described as "I want to get well and then I go home and be with my family" The overall plan for working towards this goal stated, "For me to be getting well." There were no details about what steps needed to be achieved or how progress towards this goal would be measured. The mental health care plan described the staff support as, "Staff team to administer and supervise prescribed medication. Escort to clozapine clinic monthly. Key worker, staff team to observe and monitor any significant changes in mental health and behaviour and refer [person] for review with consultant psychiatrist if unwell. Staff to maintain and reinforce set boundaries." While ensuring compliance with medication is an important aspect of maintaining mental health, there was no other guidance or information about what boundaries needed to be in place, how to set or reinforce these. There were no measures in place to establish when the person may be in a position to go home to their family, and no information about whether or not their family were willing for this to happen. This meant support had not been planned effectively to ensure that people's needs were met.

The service had training programmes in place for specific aspects of care. However, these were not personalised, or effective in supporting people to develop their skills. For example, three people had a plan in place for oral care. One person was noted as being independent with this task in January 2018. Another person's review in January 2018 noted "no teeth" but didn't say what this meant in terms of the oral care programme. A third person's review from January 2018 stated, "need to remind him" for each aspect of oral care but there were no further reviews of this or guidance about how to support the person to achieve independence.

After the inspection the provider submitted updated care plans. Although people's view on support was now included, there was no further detail in the instructions for staff about how to support people to achieve their goals.

People told us they liked the food. One person said, "I like the food here." Another person said, "I eat the food I like." There was a weekly menu in place and we saw people were able to comment on it during house meetings. People had information about their dietary needs and preferences in their care plans. However, the information was limited and we saw people were not being supported in line with the information in their care plans. For example, one person's risk assessment noted they were overweight and stated, "[Person] to eat healthy food supplied / prepared by the home, has tendency to overeat. Staff to maintain [person's] needs and promote healthy eating." On the day of the inspection the menu stated 'take-away' for lunch, which was chicken and chips from a local shop. This person told us they did not like the takeaway so prepared their own lunch. We saw staff did not provide any advice or guidance to this person who ate four slices of bread and jam and three mini-trifles for their lunch. They were not prompted to eat more healthily, were given no guidance about portion size and were not eating food supplied or prepared by the home. In addition, this person was on medicine to manage their cholesterol, and this was noted in their healthcare records as being a risk, but there was no information for staff about how to support this person to adhere to a low cholesterol diet. After the inspection the provider told us they spoke to this person about their diet regularly.

The provider submitted an updated risk assessment after the inspection. This stated the person ate take-away once a week, which was the opposite of what the person said. They told us they did not like the takeaway which was why they prepared their own lunch. The guidance for encouraging a healthy diet remained insufficient and the updated information did not reflect this person's needs or preferences.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records confirmed they received supervision in line with the provider's policy. However, the records were contradictory. For example, one staff member had an action plan in place regarding engagement and activities but the summary stated the staff member "Engages well with residents, engaging them in activities / hobbies and interests." As with the care plans, the goals for staff were not specific and there were no timeframes or measures in place to ensure staff achieved their objectives. There was no consideration of staff wellbeing in any of the supervision records viewed.

Staff told us they completed a variety of training courses. One staff member said, "We do e-learning throughout the year. An outside training did a refresher course on mental health." Another staff member said, "The online training is good as a refresher." The provider submitted a training matrix which showed staff received training in areas relevant to their role, such as mental health, aging, activities and exercise. The training records maintained by the provider were not robust; they were simple lists of training courses and did not demonstrate staff competence and knowledge had been assessed. The date training was completed was not always recorded so it was not possible to tell if training was current.

The provider told us they worked with other organisations to ensure people received effective care and treatment. However, this was not clear from the records viewed during the inspection. People's activity timetables did not show the service worked with other organisations. The provider told us they telephoned other services regularly to ensure effective joint working, but this was not recorded.

People told us staff supported them to go to the doctor if they were unwell. Records showed people were supported to access healthcare services and attended regular medical appointments with staff support. However, information about people's healthcare needs were not clearly captured within the files. For example, a letter from the hospital showed one person suffered from a drug allergy but this was not contained within their health information. This person's health care plan stated, "Appears physically fit."

Records showed this person had undergone surgery and treatment for cancer, and was seen regularly by healthcare professionals in relation to this. However, there was no guidance for staff about what would constitute a concern to escalate to healthcare professionals.

People living in the home were diagnosed with long term and enduring mental health conditions. The guidance for staff in terms of how to support people in relation to their mental health was limited to ensuring they adhered to their medicines regimes. Although there were descriptions of behaviours that may indicate relapse, there was no guidance about how to respond to people's enduring symptoms, delusions and hallucinations. For example, the strategies to respond to one person experiencing increased symptoms was, "Offer him cigarettes." This person had stopped smoking in May 2018. This meant there was insufficient up to date guidance on how to respond to people's mental health needs.

The provider had recently refurbished the kitchen and made a downstairs bathroom accessible in response to the changing needs of people living in the home. Following the inspection the provider sent us photographs to show action had been taken to improve the upstairs bathroom. They told us this work had been scheduled before we inspected.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made appropriate applications for people to be deprived of their liberty and any conditions imposed on the DoLS were being adhered to. For example, one person was being supported to arrange a holiday to their home country as this was a condition on their DoLS authorisation.

People told us they were offered choices, and the provider told us they worked on the presumption of capacity. However, care files contained no information about the nature of decisions people could and could not make, or the support they needed to make their own decisions. For example, although two of the people whose files we reviewed were subject to DoLS there was no information about whether or not they could consent to other aspects of care, or how they expressed other choices. Staff described how they offered people choices in various formats to ensure they were making meaningful decisions.

Requires Improvement

Is the service caring?

Our findings

We saw staff did not always show respect to people through their actions. For example, the provider re-arranged one person's clothing without talking to them first while engaged in conversation with the inspection team. Although the person did not object, it demonstrated a lack of respect to the person to adjust their clothing without seeking permission or offering an explanation. The tone of conversation with people was often directive. For example, when one person came to collect their daily money allowance the provider said to them, "Right, you're taking £20 and will bring back the change." Records showed this person had been managing such amounts of money independently for years.

Likewise, the tone of some of the records did not uphold the person centred values of the organisation and did not show a respectful attitude towards the people who lived in the home. For example, two people's monthly keyworker summaries stated repeatedly that their behaviour was "good" during the month. A third person's daily notes stated, "Staff encouraged him to do his personal hygiene whom he obeyed sensibly."

Although people and staff had developed positive relationships, and staff were able to demonstrate they knew people well, this knowledge was not reflected in the records. People had a document called a life story book. One person's noted they had refused to complete it in October 2017 and there was no record to show it had been re-visited since then and the point of inspection in August 2018. Another person's life story book contained conflicting information about their religious beliefs; two religious were listed as was their wish to be supported to attend their place of worship. Although staff knew which place of worship to support them to attend, the details were not in the care plan or activity schedule which meant new staff did not have easy access to this information.

People's religious beliefs were captured as part of the assessment, however, the impact they had on people's support preferences were not recorded. For example, although it stated one person wished to follow their faith's religious holiday and festivals, there was no information about what these were or when they took place. The provider told us they knew this information as they shared the same faith, but this was not true for all the staff team. Another person followed a different faith, and it was noted that a particular festival was important to them but there was no information about when this festival took place or how they should be supported to celebrate it.

The impact of people's cultural background was also not considered in terms of care planning. For example, several people who lived in the home had been born and brought up abroad. There was no information about how to support them to maintain their links with their cultural heritage within care files. Two people whose files we reviewed had English as an additional language. We saw one person in particular responded positively to being able to speak their first language with a member of the inspection team. They sought out the team member repeatedly and recited poetry and spoke about home. Both of these people's care files stated they were able to understand English but there was no plan in place to ensure they were given opportunities to communicate in their first language or access groups or activities that reflected their cultural background.

Care plans contained information about people's families and relationships. However, family member's names were not always included and the support people needed to maintain their relationships was not clear. For example, one person's file only named one of their children and did not say what their wife was called. None of the care files contained information about people's sexual or gender identity and the impact this may have on people's support preferences had not been considered. Staff were asked if anyone identified as lesbian, gay, bisexual or transgender (LGBT) and what impact this may have on their support preferences. Two staff both said, "I'm sorry I don't know." This meant there was a risk that people did not receive appropriate support in relation to their sexual and gender identity.

After the inspection the provider submitted equality and diversity monitoring forms. These did not include any additional information about how people's religious beliefs, cultural background, or relationships affected their care preferences.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring people's religious, cultural, sexual and gender identities are supported within a care setting.

During the inspection we saw staff knocked on people's doors and waited for a response before going into people's bedrooms. Staff described the steps they took to ensure people's privacy was respected. One staff member said, "Before I go inside to their room I will knock on their door, and wait for their response before I go. When they are lying down in the lounge area, I'll also leave them alone as they are resting."

Requires Improvement

Is the service responsive?

Our findings

In June 2016 we identified that care plans lacked detail about the precise nature of support and the provider told us they would update care plans to reflect the detailed knowledge of staff. They had not done so, and care plans continued to refer to "support" and "encouragement" without defining this. Care plans were not personalised and were not being updated to reflect changes in people's needs.

For example, the laundry programme in place for two people whose files were reviewed were identical. These had last been formally reviewed in January 2018, despite being in place for since at least 2016 one person's progress review stated in the outcome area for separating whites from coloured "He won't do it." The comments and observations were recorded as, "Need staff support." There was no plan to improve the person's skills. Likewise, in terms of their cooking programme each step stated, "He forgets to follow procedures." The comments were, "Staff needs to remind him" and, "Overall he need improvement." Despite these observations there had been no adjustments made to the programme or guidance to support the person to make any improvements. There had been no consideration of the reasons why this person had failed to make any progress or whether the programme and goal were suitable for them.

The home operated a keyworking system. This meant each person had a named member of staff who took responsibility for updating their files and paperwork. However, none of the people we spoke with could identify their keyworkers by name. Each month, keyworkers completed a monthly summary but these did not show people had been involved in the process of reviewing their care plans and progress. The keyworker records showed the staff observations of the person. One person's stated the same thing for four months. It stated, "[Person] appeared to be mentally stable throughout this month. Their care plan has been reviewed and updated. Keyworker section has been conducted 1:1 basis. Their ADL [activities of daily living] is safe environment. There were no changes in their routine medication, care plans and risk assessments. They participated in activity programmes. They have good appetite and their behaviour was good." This person was able to articulate clearly what their goals were and these had not been considered in the keyworker records. None of the monthly records showed any review of goals or adjustments to care plans or risk assessments, even when the observations described incidents that had occurred.

Staff recorded the support they provided to people in the daily records. This showed the support they had provided to people. However, the details of the activities people had engaged with were limited. It was recorded when people attended their place of worship, or health appointments. The home provided activities through their training and development centre. However, although this was included on people's daily schedules, it was not clear what training or development people were achieving through attendance. People had not completed any qualifications. A support worker told us, "They listen to music, play pool or use the internet. This is part of their daily activity." The purpose or goal of these activities was not captured. One person had regular "Music appreciation sessions" on their timetable, but there was no information or guidance about these sessions and what they hoped to achieve.

Care plans and risk assessments contained out of date and historic information. Two people's care files contained information about behaviours which had not been observed for over 5 years. The provider told us

care plans were only retyped every six months and updates were handwritten on the back. Where significant changes had taken place the out of date information remained prominent until a fixed date had been reached. This meant there was a risk people did not receive the correct support as care plans had not been appropriately updated.

Assessments and care plans contained no information about people's wishes should they reach the end of their lives. There was no record to show people had been asked to think about what treatment they may, or may not, wish to consider in the event of a life-changing or life-limiting health emergency. Care files did not contain any information about how people would wish their bodies to be cared for in the event of their deaths, or who they would wish to be informed and involved in arranging their end of life care. The cultural and religious customs of people had not been considered despite people practicing faiths which have particular considerations for the care of bodies after death. This lack of information meant there was a risk that people's wishes with regard to end of life care would not be respected as they had not been identified. After the inspection the provider told us people had funeral plans in place.

The above issues with the quality of care records are a breach of Regulation 9 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

People told us they would raise any concerns or complaints with the provider. There was a complaints policy in place, which was on display in the home. This included details of the expected timescales for response and investigation as well as how to escalate concerns if people were not happy with how the complaint was resolved. There had been no complaints since our last inspection.

The home held house meetings every three months. The records showed these were used to convey information from the provider to people and there was limited involvement of people who lived in the home. For example, the May 2018 meeting records showed reviews had been discussed and stated, "This [reviewing] is a regular ongoing process and you should be proactive in contributing to your review and care plans with our keyworkers." Regarding the bathrooms this meeting had recorded, "Bathrooms have been re-modelled, decorated and new floors. But residents have already damaged the bathroom. It is your home and you should look after it. Any deliberate damage will be paid for." This was repeated from the February 2018 meeting where it had been recorded that "Damage is not acceptable and will be paid for." In May 2018 the only evidence of people's involvement was the 'any other business' agenda item which stated, "Residents are happy with things in the home, no problems reported." In February 2018 it was only with regard to the menu that people's views were captured; people were happy with the menu options. It was not clear people were given regular opportunities to provide feedback which could be used to improve the quality of care.

Requires Improvement

Is the service well-led?

Our findings

In June 2016 the provider had made a commitment to us that they would update care plans, risk assessments and medicines records in response to feedback given during that inspection. They had not done so, and care plans and risk assessments had not improved in their quality since then. When this was discussed with the provider they told us they believed submitting one updated care plan had meant they had done enough. The report from 2016 was clear the provider had committed to completing further work. In addition, the local authority had completed a monitoring visit in April 2017 where they had made similar recommendations regarding care plans, activities, risk assessments and engagement. The provider had not followed these recommendations.

Providers are required to notify us of specific events. This includes when people have Deprivation of Liberty Safeguards (DoLS) authorised. The provider told us four people were currently subject to DoLS. However, we had only received one notification regarding one person's authorisation.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The providers knowledge of best practice within the field of supporting people with mental health conditions and adult social care in general was not sufficient. Care files did not reflect current practice in terms of supporting people with mental health issues. There was a lack of goal focus and no guidance on how to maintain recovery. Staff had no information on how to respond to expressions of delusions or hallucinations. Information was limited to ensuring people attended medical appointments and were compliant with their medication. The provider asserted they did not support people to take controlled drugs, despite one person being prescribed a controlled drug.

The provider completed monthly quality assurance audits. These were ineffective and had failed to identify issues with the quality and safety of the service. The audits covered the premises, medication, health and safety, hygiene control and infection, food, nutrition and hydration, care plans and risk assessment and training. These audits had failed to identify issues with condition of the building and garden, although they did note some maintenance issues. They had failed to identify the widespread issues with the quality and detail of care plans and risk assessments.

The audits all stated health and safety checks were completed and were all satisfactory. However, we reviewed the checks of the hot water taps and found they did not demonstrate safe practice in terms of hot water temperature monitoring. It was not clear which outlet was being tested, however, from January until August 2018 the monthly checks had recorded the water temperature as being between 47 and 49 degrees. Above 44 degrees there is a significant risk of scalding and the provider had not taken steps to mitigate this risk in line with health and safety executive guidance. After the inspection the provider told us they had added warning signs and changed the style of tap to mitigate the risk of scalding.

The previous registered manager had sadly died shortly after our last inspection and had been removed from the register. Although the provider was registered manager of a different location, they were not

registered for Lyncroft. They applied to add this location to their registration after being asked to by the inspection team.

The provider had completed satisfaction surveys with both people and staff. The staff survey had no actions attached to it as staff had only provided positive feedback. Feedback from people had also been positive, but the report had included actions such as, "It would be advantageous to seek dietician advice and guidance." And, "Key workers should take a proactive role in residents' personal care and be available for support and guidance. Management to provide necessary guidance and advice to keyworker in provision of personal care and support whenever necessary." These had not been discussed in supervisions or staff meetings and there was no action plan to ensure these steps were taken or monitored. After the inspection the provider told us these actions were discussed but not recorded.

We asked the provider if they had an action plan in place, or development plan for the service. They told us "I don't think it's been updated. It's an ongoing programme of work." For an action plan to be a useful tool to ensure the development and progress of a service they should be keep live and up to date. After the inspection the provider clarified they had an action plan in place to develop and promote the business. They did not consider actions from staff and service user surveys appropriate to include in this action plan and were considering a way of recording this information.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us they could raise issues with the provider and they could ask questions. Records of staff meetings captured a directive tone, and did not capture if staff were given the opportunity to ask questions or raise issues. Staff meetings took place every three months and records showed staff were reminded of their duties and responsibilities. For example, in May 2018 there had been a discussion about staff breaks. The record stated, "All staff must now phone and inform [Provider] when they go on a break and when they return. Do not go next door and stop other staff from working."

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 9 HSCA RA Regulations 2014 Person-centred care Needs assessments and care plans lacked detail and did not reflect people's current needs and preferences. Regulation (9)(1)(b)(c)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been appropriately identified or mitigated. Systems did not ensure the safe management of medicines. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not kept suitably clean or hygienic. Regulation 15(1)(b)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to ensure the quality and safety of the service. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff had not been effectively deployed as they were working excessive hours. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notification as required.

The enforcement action we took:

We issued a fixed penalty notice which the provider paid in full.