

Bupa Care Homes (ANS) Limited

# Lynton Hall Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Lynton Hall Care Home is a care home providing personal and nursing care for up to 48 people. At the time of our inspection, there were 40 people using the service. The service supported older people living with dementia and nursing needs. The home is arranged over two floors, each with their own separate adapted facilities.

### People's experience of using this service and what we found

We found evidence during our inspection of two breaches of regulation and the need for this provider to make improvements. Staff did not always follow appropriate procedures in making sure they effectively managed people's pressure ulcers and there was a lack of management oversight to ensure good practice.

Staff did not always receive on-going support on the job to ensure they carried out their roles as necessary. This included a lack of regular supervision, appraisal and observation on the job. People and staff reported that they felt more staff were needed to meet people's wishes and choices. We have made recommendations about this.

Healthcare professionals told us their working relationships with the provider were not always effective.

More positively, people felt that staff were caring and that their care and support needs were met effectively. Medicines were managed consistently and safely in line with national guidance. Infection control and prevention guidance was followed effectively, including those associated with COVID-19, to prevent people and visitors from catching and spreading infections.

The service was working within the principles of the Mental Capacity Act (2005) and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Where people required support to meet their nutritional needs, staff provided the required care. Training was available to help staff to meet people's care needs related to their health conditions. Staff ensured that people had access to healthcare support as required.

People told us there was good leadership at the service and they felt confident to raise concerns with the staff team as and when required.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last overall rating for this service was good (published 19/07/2018).

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lynton

Hall Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### Why we inspected

This inspection was prompted by a review of the information we held about this service and recent safeguarding activity. This was a focused inspection and the report only covers our findings in relation to the Key Questions Safe, Effective and Well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We identified two breaches in relation to safe care and governance systems. This was because the provider failed to ensure they always consistently managed the risks associated with people's pressure ulcers. The service did not always operate their established governance systems effectively.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and the relevant local authorities to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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.  
Details are in our safe findings below.

**Requires Improvement**



### Is the service effective?

The service was not always effective.  
Details are in our effective findings below.

**Requires Improvement**



### Is the service well-led?

The service was not always well-led.  
Details are in our well-led findings below.

**Requires Improvement**



# Lynton Hall Care Home

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

The inspection was carried out by two inspectors, a specialist advisor and Expert by Experience. The specialist advisor was a nurse. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

Lynton Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Lynton Hall Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

Our first visit to the care home was unannounced. We gave the service 24 hours' notice before we visited the second time. This was because we needed to be sure that the management team would be available to support the inspection when we visited.

#### What we did before the inspection

We reviewed information we had received about the service since our last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed intelligence information we held on our system including notifications about important incidents.

#### During the inspection

We spoke with nine people who used the service and a friend of a resident about their experience of the care provided. We also spoke with the regional director, supporting manager, registered manager and 10 staff members, including nurses, care assistants, activities co-ordinator, maintenance staff, chef and cleaner. Where people had limited verbal communication, we observed their interactions with support staff.

We reviewed a range of records. This included people's care and risk management plans, multiple medicines management records, staff files in relation to recruitment and training data. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

We contacted four healthcare professionals to find out their experiences of working with this provider.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Assessing risk, safety monitoring and management

- Risks related to people's pressure ulcers were not always managed safely.
- At the time of inspection, a safeguarding outcome was received noting that a person was at risk of neglect because of poor management of pressure sores at the home. At the same time, two other safeguarding investigations were taking place related to the management of pressure sores.
- During our visit we also found that records in relation to the pressure sores were not always properly completed to ensure on-going monitoring of people's wounds. Three out of four people had recording gaps for turning and checks of pressure support equipment.
- The provider took actions in response to these concerns. They promptly completed an internal quality assurance assessment on improvements required in relation to the pressure sores management at the service. They also had training arranged for the nurses to attend to enhance their skills in management of pressure sores.

Despite the action taken by the provider, the provider's monitoring systems were not robust enough to ensure staff effectively managed the risks associated with people's pressure sores. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were care plans and risk assessments in place to recognise people who may need further provision and help to keep them safe. Risks assessments were carried out before people moved into the home and these were reviewed soon after the person moved in to check that all risks had been properly identified. There were risk assessments associated with people's mobility, management of medicines and pain, diabetes and behaviours that might challenge staff. The instructions in care plans about how to manage these risks were clearly recorded.

### Staffing and recruitment

- Although people told us their care needs were met and the call bells were answered in good time, they felt that staffing levels were not always sufficient to ensure they received the care that met their choices and wishes. People's comments included, "I would like to choose when I get up and go to bed but it has to be fitted in" and "[Staff] do listen but are really too busy to do anything extra." Some people told us they would like to go outside in the garden, but that staff were not always available to support them.
- Some staff told us there weren't enough staff to ensure good care delivery. They said, "It is exhausting, you never stop for five minutes. Not enough staff. In training they say it is a double up care, but like today we have three staff and people have to wait so we can support them" and "We are always always short staffed..."

We don't get to take a break sometimes... If we take our time, we can't get through everyone."

- Rotas viewed showed that staffing levels had fluctuated. The management team told us that agency staff were used to cover shifts when needed and that the service was in the process recruiting to ensure they had enough staff to cover the shifts as necessary.

We recommend the provider to review their staffing levels making sure there was enough staff to meet people's care needs safely and in accordance to their preferences.

- Staff were suitably recruited.
- Checks were carried out prior to staff commencing work for the provider. Staff had to attend an interview, provide references and undertake a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- Staff had a good understanding of what they needed to do to make sure people were safe from harm and potential abuse. Staff received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. One staff told us, "Hoisting is always done by two people. If not, it is a safeguarding as someone can fall out. I would report the incident and inform the nurse." The provider had a safeguarding adult's policy and procedure and staff were aware of this.
- Systems were in place to monitor any safeguarding concerns received, including the date and details of the abuse allegation.

Using medicines safely

- People received their medicines as prescribed with dedicated trained staff to manage stock control, ordering and safe storage of medicines.
- People told us they had confidence in the staff who supported them with their medication. Staff were aware of good practice guidelines, with one staff member telling us, "I take medication very seriously, it is a big responsibility and I am very careful. I have support and good training."
- The Medication Administration Record (MAR) charts were properly completed and were easy to follow.
- People's medicines were kept securely, and only appropriately trained staff had access to this. The medicine's room temperature was checked and recorded regularly.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider's infection prevention and control policy was up to date.

The provider followed current government guidelines in relation to the visiting arrangements at the service and ensured visitors to the home followed infection control procedures.

Learning lessons when things go wrong

- Systems were in place to ensure that if an incident and accident occurred, it was promptly recorded and investigated. Incident records included a review of the incident and an action plan to prevent similar incidents taking place.
- Where incidents or accidents occurred the provider took appropriate action to ensure people's safety. This included the prompts being added to care plans for staff to follow to ensure safe manual handling procedures.



# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support; induction, training, skills and experience

- People felt that staff were well trained. They said, "Well, [staff] seem to know what needs doing" and "I am transferred using a hoist and [staff] make me feel perfectly safe."
- Staff were provided with the mandatory training courses to ensure they had the necessary knowledge and skills to support people effectively. This included training in Dementia awareness, safeguarding, first aid, health and safety and medicines management.
- Staff told us they received the necessary support on the job to meet their role expectations, with one of them saying, "We have nurses that we can ask anything and they are helping. They are willing to help so we are not lacking in this area."
- However, supervisions, appraisals and observations were not carried out regularly to monitor staff's performance. We also saw that records in relation to one to one meetings with staff were not always detailed enough addressing the issues identified, for example in relation to people's oral and nail care.
- This was discussed with the management team who promptly sent us an action plan noting how they planned to improve in this area.

We recommend the provider to review their systems in place making sure staff received on-going support on the job to carry out their responsibilities safely and effectively.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Moving and handling of people was done safely at the service and in line with their assessed needs. We observed staff using effective moving and handling techniques when transferring people. They talked to people to give reassurance when hoisting. There was also guidance displayed beside hoists about proper use of equipment. Staff confirmed their manual handling training was updated yearly, commenting "I always transfer with two people and I have been trained. We have enough equipment and people have their own slings."

Supporting people to eat and drink enough with choice in a balanced diet

- People's nutritional needs were met as required.
- People told us they were provided with a choice of meals. Comments included, "The food is very nice and we are always given choices" and "[Staff] are always offering extras, cakes and tea." There was a flexibility to meet people's cultural preferences such as requests for spicy and vegetarian food. One staff member said, "We talk to people and try and see how to help them choose what they like to eat. We are very respectful of people's culture and their food preferences."

- People's complex care needs in relation to eating and drinking were assessed and managed, along with any associated risks. Staff involved health and social care agencies when needed, and followed the recommendations made to meet people's best interests.
- Food and fluid charts were recorded accurately. Where a person was at risk of malnutrition or losing weight, this was clearly recorded and managed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People had access to healthcare services as necessary.
- People told us that staff were aware about their health care needs and that medical support was provided to them if they felt unwell. Comments included, "[Staff] are first class, they know me very well" and "[Staff] tell me they are going to get the doctor and then they do."
- People had hospital passports to be taken with them if admitted to hospital which helped to ensure they had the necessary support.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- People were supported in line with the MCA and provider's policies where restrictions such as bed rails were used to ensure their safety. Records showed that bed rails were used for one person who did not have capacity to consent to this but this decision was made in their best interests involving the person's relative. Where a person had capacity to give consent, the file contained evidence on how the person demonstrated they understood the need for this restriction.
- Staff knew how to support people's rights in the decision making process. One staff member told us, "If I am helping a resident with personal care, I definitely ask if its ok if I do this to you and go ahead if they want to."
- DoLS were applied properly and when people needed it.

Adapting service, design, decoration to meet people's needs

- We observed people moving around the home easily where they used walking equipment to support them. Open plan sitting and dining areas offered people opportunities to gather together and interact when they wanted to.
- We observed the garden area requiring some maintenance. The registered manager told us they had a budget allocated and that they planned to make improvements in the nearest future.

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Although quality assurance processes were in place, these were not always operated effectively to ensure people's safety. Provider's failing to identify and/or take appropriate action to address pressure ulcers management at the service resulted a person being harmed. There was also a lack of management oversight in relation to staff support and staffing levels making sure people received the care that met their choices and wishes.

- During the inspection we found that the provider had not always notified the CQC about the events that affect the care provision. This included the CQC notification not being sent in relation to pressure ulcers obtained by people. The registered manager acknowledged this short fall and told us they would amend this concern immediately by adjusting the systems in place by prompting them to send the notifications as necessary.

The above meant that governance systems in place were not always operated effectively to minimise the risks associated with people's safety. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection we were informed that management changes were planned at the home, including the new management team being appointed to take over the running of the service. Plans were in place to ensure good support for the new managers, including appropriate handover so that the impact on the service delivery was minimal.

Working in partnership with others

- The healthcare professionals told us they did not always have an effective working relationship with the service. Comments included, "I and the relatives have found it very frustrating, because actions that have been agreed at previous [name of the meeting] still have not been completed a year and a half later" and "I found [the registered manager] did not proactively or timely provide answers to my questions, seemed disorganised and I had to constantly chase him."

- This was discussed with the registered manager who told us that the management capacity was increased recently. They hoped this would result in more effective delegation of duties and an improvement in their working relationships with healthcare professionals. We will check their progress at our next planned inspection.

Planning and promoting person-centred, high-quality care; Duty of Candour

- There was a supportive culture at the service focusing on providing quality care for people.
- People described staff as "pleasant and friendly", "nice and they are kind, never a cross word" and "like a big family."
- We observed that staff treated people with respect, compassion and dignity. People enjoyed talking to staff. Staff knocked and waited before entering people's rooms. People were actively encouraged to be as independent as they wished to be, with appropriate risk assessments in place to ensure their safety.
- The staff team worked together to support people's care needs. One staff member told us, "[The registered manager] has an open door policy and nothing is too much for him. He will always back us up. He is very behind the residents, families and staff. Absolutely addressing the concerns." Team meetings took place to agree and follow-up on actions necessary.
- The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour providers must be open and transparent if things go wrong with care and treatment. During the inspection, the service had applied duty of candour where appropriate and honestly shared information with us relating to difficulties they were facing. This included the challenges they had to overcome during the pandemic to support staff so that safe and effective care was provided for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they felt confident to raise concerns and were listened to, with one of them telling us, "I complain if I have a need, but so far just to a nurse or carer."
- There was a suggestion box for family and friends to use in the entrance hall if they wanted to feedback about the service delivery. Records showed that people were provided with opportunities to discuss their care on individual basis and when they wanted to make changes.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People who use the service had been placed at risk of harm because the provider had failed to ensure the proper and safe management of people's pressure sores. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People who use the service were not protected against the risk of receiving poor quality or unsafe care because the providers oversight and scrutiny processes were not always effectively managed. Regulation 17(2)(a)(b)