Care Quality Commission

Bupa Care Homes (ANS) Limited

Lynton Hall Nursing Centre

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 and 16 December 2014. Several breaches of legal requirements were found and the Care Quality Commission issued two warning notices for breaches of Regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to Regulation 17 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they have met the requirements of the warning notices. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lynton Hall Nursing Centre on our website at www.cqc.org.uk.

Lynton Hall Nursing Centre provides accommodation and nursing care for up to 57 older people. There were 43 people living at the home when we visited, one person was in hospital. The home was based on two floors, the ground floor for people with nursing care needs and the first floor for people living with dementia. There were bedrooms, bathrooms and communal rooms on both floors. Each person has their own room.

The home had a registered manager who was on leave at the time of the inspection. The home was being supported by a registered interim manager from another local BUPA home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to

Summary of findings

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.

We found that the doors to both sluice rooms were locked and individual risk assessments were updated. Staff explained to us the schedule for ensuring how they would assess people most at risk based on the level of risk they faced. We saw that a behaviour observational chart was in use for people who had behaviours that challenged. Plans were now in place to monitor accidents and falls and evaluate why they had occurred. These included measures to mitigate further risk of accidents or falls.

The provider continued to conduct monthly reviews of the service and an action plan was developed. The outcomes of the action plan were monitored more robustly than during our previous inspection and evidence compiled that the areas for improvement were being addressed and these were signed off when completed.

People were able to participate in making decisions regarding their care or treatment and were treated with consideration and respect.

Over the lunch period in the ground floor dining room and saw that interactions between staff and people were positive. People were asked if they would like to wear a clothes protector and what they would like for lunch. We saw that staff spoke kindly to people before helping them and engaged people in conversations during the lunch period.

The care we saw that was given to people was good and an improvement on our last observation. The area manager said there was still more work to be done. We saw that staff now had dedicated lunch and break times. This ensured there was always sufficient staff to help people, especially after meal times. We saw that people who choose to stay in their rooms had a call bell near to them and staff came within a very short time, less than three minutes when the bell was pressed.

We heard staff speaking to people throughout the house in a positive and friendly manner and engaging people in conversations. People confirmed they were treated with respect and dignity and could have a bath or shower when they wanted to.

People in the first floor were engaged in an activity and quiet music was play in the background. Staff were talking to people and helping one person who was restless on a one to one basis and this appeared to calm them.

We saw that medicines waiting to be returned to the pharmacy were kept securely in a locked cupboard. There was a monthly schedule for updating care plans and staff confirmed our observations that this was happening.

The area manager said they had engaged people in making changes to the lounge areas. We saw the changes meant people and staff could speak to one another while activities were taking place and other people could go into a quieter area of the lounge.

We saw that the majority of food and fluid charts were now completed correctly.

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?

Inadequate

We found that action had been taken to improve safety in the specific areas we looked at.

Risk assessments for people were being updated and actions taken to mitigate further risks to people

Accidents and falls were monitored and evaluated and actions put in place to keep people safe.

However, we could not improve the rating for 'Is the service safe' from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service caring?

Inadequate

We found that action had been taken to improve the way staff engaged with people and treated them.

The majority of interactions between staff and people were positive. We saw staff spoke kindly to people before helping them and engaged people in conversations.

However, we could not improve the rating for 'Is the service caring' from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires improvement

We found that action had been taken to improve the way the quality of service provision was being assessed and monitored.

The provider continued to conduct monthly reviews of the service and these were now followed through with an action plan which was signed off when completed.

There was a monthly schedule for updating care plans and people were involved in the decision making processes.

However, we could not improve the rating for 'Is the service safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Lynton Hall Nursing Centre

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 checked 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.

We undertook an unannounced focused inspection of Lynton Hall Nursing Centre on 6 May 2015. This inspection was done to check that improvements we asked the provider to make in relation to warning notices we served after our comprehensive inspection on 15 and 16 December 2014 had been made. We inspected the service against three of the five questions we ask about services: Is the service safe? Is the service caring? Is the service well led? This is because the service was not meeting some legal requirements.

The inspection was undertaken by a single inspector. During our inspection we spoke with the interim and deputy manager, the area manager, the quality assurance manager, five staff and seven people who live at the home and one relative. We looked at six care files and other information relevant to the running of the home.

Before our inspection we reviewed all information we held about the service and the provider including looking at the previous inspection report and reviewing this in line with the action plan the provider submitted to the Care Quality Commission (CQC).

We observed care and support in communal areas. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our previous inspection on the 15 and 16 December 2014 we found the provider was failing to protect service users and others against the risks of inappropriate or unsafe care because they did not have effective systems to regularly assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users.

For example, we saw the door to the sluice room on the first floor was unlocked and open, inside was an open cupboard that contained cleaning fluids. This meant that the risk of people accessing these areas had not been mitigated by carrying out appropriate risk assessments with action being taken to lessen the risks including keeping the sluices locked.

Individual risks assessments to ensure the safety of people using the service had not always been updated as required to reflect people's changing needs. This meant that people were placed at risk of receiving unsafe care and treatment.

At this inspection we found the provider had made the necessary improvements to protect people. We found that the doors to both sluice rooms were locked when we tried to open them on several occasions during our inspection.

Individual risk assessments were being updated and we saw many that had been completed. Staff explained to us the schedule for ensuring all risk assessments were updated and that those people most at risk were being prioritised.

We saw that a behaviour observational chart was in use for some people who had behaviours that challenged. This was broken down into short time frames of 15 minutes and into observation of what the person was doing and how they were feeling and behaving, such as pacing, talking, shouting and being quiet. This information was then fed back to the GP when necessary for a review of a person's medicines or additional activities were organised such as taking the person outside for a walk. This helped to ensure that people's behaviour was monitored and action taken when needed to help ensure they received safe and appropriate care.

Accidents and falls were now monitored and evaluated and measures put in place to mitigate further risk. The quality assurance manager explained that accidents and falls were now analysed on a regular basis, and referrals made to the person's GP for a review of medication if needed. The person's care plan was reviewed to reflect any changes or actions taken to lessen the risk of further accidents and falls.

Inadequate

Is the service caring?

Our findings

At our previous inspection on the 15 and 16 December 2014 we found the provider was failing to ensure that people were enabled to make or participate in making decisions regarding their care or treatment or to have their dignity, privacy and independence maintained or to be treated with consideration and respect.

Our use of the SOFI tool also showed that most interactions between staff and people were not positive. Specifically we saw that staff did not always speak to people in a positive way or engage with people while assisting them with their lunch. Staff cut up people's food without asking if they would like their food cut up. Staff did not remain with a person or sit beside them while assisting them with their lunch. Staff put clothes protectors on people without saying what they were doing or asking if the person wanted a clothes protector on.

We observed that call bells were not always in reach of people when they were in their bedrooms and staff did not respond promptly to people's call bell. People's preferences for a bath or shower were not considered

At this inspection we found the provider had made the necessary improvements to ensure that people were better cared for. We used the SOFI tool over the lunch period in the ground floor dining room and saw that the majority of interactions between staff and people were positive. People were asked if they would like to wear a clothes protector and if staff could put it on. Staff showed people two plates of the food that was on offer for lunch and asked people which they would prefer. A variety of cold drinks were also available during the meal and people's glasses were topped up only when a person asked for more or staff asked people if they would like more.

We saw that staff spoke kindly to people before helping them during the lunch period. However we did note that there were no suitable chairs for staff to sit on while helping a person with their lunch. One member of staff sat on a foot stool and another carried in a large lounge chair. Neither was ideal for the purposes of moving between people who required assistance. We spoke to the area manager about this and they said that she would look into this matter.

Although the care we saw given during the lunch period was good and an improvement on our last observation the area manager said there was still more work to be done to ensure that people received personalised care. This included ensuring only one staff member assisted a person with their lunch and stayed with them throughout the meal time.

We saw that staff now had dedicated lunch and break times which were planned. This ensured there were always sufficient staff to help people, especially after meal times.

We saw that people who choose to stay in their room had a call bell near to them even if they were unable to press the bell themselves. When call bells rang staff came within a very short time, less than three minutes.

We heard staff speaking to people throughout the house in a positive and friendly manner and engaging people in conversations. We saw that staff treated people with respect and dignity.

We asked several people whether they could have a bath or shower when they wanted to and most people confirmed they could. Two staff we spoke with said they asked people every day if they wanted a bath or shower and said the choice was the person's and that bathing didn't have to happen first thing in the morning but could now be offered throughout the day. One person told us "I'm always asked what I'd like but sometime it's [bathing] a bit rushed." Another person said "Staff are polite when they help me."

We saw on the first floor that an entertainer was performing songs and people from both floors were in the lounge enjoying the singer. In the afternoon people were engaged in an activity and quiet music was play in the background. We saw that staff were talking to people and helping them with their activity. One person who was agitated was being supported by a member of staff on a one to one basis and this appeared to calm them.

The actions the provider has taken have helped to ensure that people living at the home were better cared for and were engaging more with staff and other people in the home.

Requires improvement

Is the service well-led?

Our findings

At our previous inspection on the 15 and 16 December 2014 we found the provider was failing to protect people and others because their quality assurance systems were inadequate in assessing and monitoring the quality of the service provision. The systems were not always effective in identifying areas for improvement and for ensuring that prompt remedial action was taken to make improvements.

The provider had also not completed and returned the provider information return (PIR) as requested. 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.

The provider was conducting monthly reviews of the service. However where actions needed to be taken the provider had not done so. This included the removal of unused medicines, completing care plan updates, rearranging ground floor lounge so that chairs were not all against the wall and ensuring that food and fluid charts were completed appropriately. We saw the lack of updated care plans had been noted in several monthly monitoring reviews, but no action had been taken to make the necessary improvements.

During this inspection we saw that the provider had taken action to make the necessary improvements to protect people. Whilst we had not received the PIR, we were assured that other requests for information had been met and notifications about reportable incidents and events had been sent to CQC in a timely manner.

The provider continued to conduct monthly reviews of the service and the four areas covered were quality of care, quality of life, quality of leadership and management, quality of the environment and general observation of care.

The quality assurance manager confirmed that all four areas were now looked at and an action plan developed. The outcomes of the action plan were monitored and evidence compiled to demonstrate these were met and were signed off when completed..

We saw that actions from past audits had been met. During our last inspection medicines waiting to be returned to the pharmacy were stored in an unlocked cupboard. These medicines were now stored safely in a locked room.

There was a monthly schedule to update care plans and we saw that this was being adhered to and staff confirmed our observations.

The provider had made arrangements to review seating arrangements within communal areas to make these areas more conducive to people interacting and engaging with each other, staff and visitors. We saw that where possible staff had repositioned armchairs so people were seated in small groups. For example we noted that chairs had been moved in the upstairs lounge into two smaller areas and dining tables and chairs were moved to the side in order to give more room for people to move around. We saw that this layout meant that people and staff could speak to one another while activities were taking place and other people could go into a quieter area of the lounge.

We noted that care records to monitor people's conditions were being completed appropriately. We saw that food and fluid charts were now completed correctly, noting the amount that a person had eaten or drunk. We did see that the daily total amount of fluid drunk was not always calculated. We spoke with the area manager about this and they said they would ensure it was calculated and noted.

The actions the provider had taken have helped to make the necessary improvements in making sure the service was better led.