

Atlantis Medicare Limited

Lyndhurst Residential Care Home

Inspection report

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16 February 2023

23 February 2023

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Lyndhurst Residential Care Home is a care home without nursing care, providing accommodation for persons who require personal care for up to 42 people. The service provides support to older people, including people living with dementia. At the time of our inspection there were 26 people using the service. The care home accommodates people across 2 floors in 1 building.

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

The service had made some improvements in medicines management since the last inspection, however, we found medicines were not always managed safely. Risks were not always being appropriately identified and managed and recruitment practices were not safe. Staffing levels in the home had improved, the home was clean and tidy and infection control practices had improved. People were supported to have visitors, lessons learned were taking place and people told us they felt safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Complaints were not being acted on in line with the homes policy. Records were being reviewed but they did not always contain the necessary information. We saw evidence that people were starting to be involved in their care planning and person-centred care had improved. People's communication needs were being met. Activities were taking place and people spoke positively about the improvements in activities. Some people's end of life wishes had been considered, the home was in the process of adding this information to people's care plans.

The providers oversight of the service was not robust, the manager had however, implemented a number of audits, these needed to be strengthened to identify all the issues we found during the inspection. Incidents were still not always reported to the Care Quality Commission (CQC) when they should have been and various documents were not in place. The provider had not fully complied with the conditions CQC imposed during the last inspection. Staff meetings were taking place and some surveys had been carried out. People spoke positively about the new management and the service worked in partnership with the local authority and various health teams.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was inadequate (published 5 October 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

We carried out an unannounced inspection of this service on 4, 8 and 10 August 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. 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 remains inadequate. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lyndhurst Residential Care Home on our website at www.cqc.org.uk.

Enforcement

We have identified continued breaches in relation to medicines management, risk management, failure to send appropriate notifications to CQC, recruitment, complaints management and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Lyndhurst Residential 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 3 inspectors (1 of which was a pharmacy inspector) and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Lyndhurst Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Lyndhurst Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there

was not a registered manager in post. A new manager had been in post for approximately six months and had recently submitted an application to register.

Notice of inspection

This inspection was unannounced. Inspection activity started on 14 February 2023 and ended on 23 February 2023 when we delivered remote feedback. We visited the location's office/service on 14 and 16 February 2023.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who works with the service. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. This is covered in more detail in the well-led domain. We used all this information to plan our inspection.

During the inspection

We spoke with 8 people who used the service and 5 relatives about their experiences of the care provided. We spoke with 8 members of staff including the manager, deputy manager, senior care workers, care workers, domestic staff, general manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records, which included detailed reviews of 3 people's care plans, 6 medicine administration records and we looked at medicines related documentation. We also observed medicines administration and checked storage. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to demonstrate medicines safety was effectively managed. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not managed safely. The service had recently moved over to electronic systems for recording of medicines administration (eMAR). Although staff had been trained on the use of the eMAR system, its functionality was not fully embedded in the home. This was apparent due to conflicting information across systems, and staff failing to understand where the issue was.
- Thickening powder used in drinks for people who were at risk of choking was not always recorded accurately. People's records did not always have the correct information in place to guide staff on how to administer the thickener, and systems used to record when thickener had been added to drinks was not always accurate. This meant there was a risk people were not being supported safely with their prescribed thickeners.
- Staff did not always have access to information on where to apply topical medicines such as creams.
- Although temperature monitoring of the storage area was taking place, the service only recorded the current temperature of the room and did not take into account the minimum and maximum temperatures of the day. On the day of the inspection the maximum temperature had exceeded the recommended range for storage of medicines. Although some action was taken, further checks were not in place to ensure the temperature issue had been rectified.

We found no evidence that people had been harmed. However, medicines management was not always safe which put people at risk of harm. This was a continued breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medication concerns had been identified on our previous 2 inspections.

- Staff had received medicines training and had their competency assessed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure that effective systems were in place to assess,

monitor and mitigate the risks to people's health and safety. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks were not being appropriately assessed and managed. Risk assessments were not in place around ongoing redecoration work in the home, which could lead to risk of harm to people being unmanaged. The general manager started to implement these risk assessments during the inspection.
- Risks relating to people's health was not being appropriately assessed. For example, 1 person's care plans stated they were at risk of falls, but a falls risk assessment was not in place. Another person's care plan identified they had type 2 diabetes, but it was not clear how this condition was being monitored and if a risk assessment around this condition was needed. Additionally, a mobility risk assessment was incomplete, and this person required support mobilising. One person's communication care plan did not refer to their visual impairment or whether they had any associated risks or support needs around this condition. This put people at increased risk of harm.
- Personal Emergency Evacuation Plans (PEEPs) had been implemented for all service users, however, the file was not up to date as it contained a PEEP for a service user who had passed away. PEEPs provide information to staff and the emergency services for how to evacuate people in the event of an emergency. An additional PEEP left in the folder, means the fire brigade could potentially enter the building in the event of a fire and be looking for a person that is no longer in residence.
- Legionella risk assessments were in place, and regular flushing was taking place of any bedroom outlets, however, there was no recent records relating to flushing of the communal bathrooms and toilets.

Systems were either not in place or robust enough to demonstrate safety and records relating to risk was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns relating to risk had been identified on our previous 2 inspections.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment

At our last inspection the provider had failed to operate an effective recruitment process. This was a breach of regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 19.

- Systems and processes were not always being followed to support the safe recruitment of staff. Two staff members did not have all necessary pre-employment checks in place before starting in their role, including references and a Disclosure and Barring Service (DBS) check. A DBS provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- 2 staff members had gaps in employment which had not been addressed, and 1 staff member had not listed their previous employment or education on their application form and this had not been followed up during the recruitment process.

The provider had failed to operate an effective recruitment process. This placed people at risk of harm. This was a continued breach of Regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure appropriate staff were deployed to provide required care and that staff were up to date with necessary training. This was a breach of Regulation 18(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- Staffing levels were safe and training compliance rates had improved. Agency use had steadily declined since the last inspection. At the time of inspection, there had been no recent use of agency staff.
- People and relatives told us there was enough staff. Comments included, "There are always enough staff." and "The staffing seems to have settled down now and there are not as many agency staff being used." Relatives told us, "Before Christmas, there were too many agency staff. Now it's a more regular staff" and "There do seem to be enough staff through the day when I visit."
- Staff said staffing levels had improved. They said, "They (staffing levels) are better." and "I think the staffing levels seem fine."

Preventing and controlling infection

At our last inspection the provider had failed to ensure appropriate processes were being followed regarding IPC practices. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach regarding IPC practices.

- IPC processes had improved in the home and records reflected this. However, unlabelled toiletries were still left in communal areas which posed an infection risk. The manager removed all communal toiletries immediately and disposed of these.
- 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 was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- People were supported to have visitors in line with current government guidance

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were in place to safeguard people from the risk of abuse. A safeguarding policy and procedure was in place and included information on how to escalate concerns.
- People told us they felt safe. One person said, "I feel safe and I can't find any fault with this home."
- Staff were able to provide examples of what they would report to safeguarding.
- Incidents had appropriately been referred to the local safeguarding team to keep people safe.

Learning lessons when things go wrong

- Some lessons learned were taking place and being recorded, though further work was required. This is covered in more detail in the well-led domain. We did not see any evidence of lessons learned outcomes being shared at staff meetings from the minutes we reviewed. Following the inspection, the manager said they would record this. The general manager later told us that lessons learned was filtered back to staff at flash meetings.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to ensure systems and processes were being followed to ensure complaints were being appropriately logged and recorded. This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 16.

- Although systems and processes were in place to ensure complaints were received and acted on appropriately, these were not always being followed. The home had a complaints file, complaints and concerns raised by family members were recorded and resolved, however, the complaints process had not been followed. Complainants had not been issued with an acknowledgement letter or resolution letter as per the services policy.
- Complaints were not always being appropriately logged which made it difficult to understand if they were being responded to appropriately. On speaking to 1 family member, they told us they had raised 2 complaints which they had not received any documentation for. However, on speaking to the manager, they told us that they felt these were raised as queries not complaints.

We found no evidence people had been harmed. However, the provider had failed to ensure systems and processes were being followed to ensure complaints were being appropriately logged and resolved. This was a continued breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to demonstrate clear and accurate records were being maintained in relation to the care and support people received. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- We found records were being reviewed more regularly though they did not always contain the necessary

information, this is covered in more detail in the safe and well-led domain.

The provider had failed to ensure good governance. This placed people at risk of harm. This was a continued breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed ensure systems and processes were in place and being followed to ensure that people received person centred care. This placed people at risk of harm. This was a breach of Regulation 9 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

- People's care records had been put onto a new system and we saw some evidence of people and their relatives starting to be involved in the care planning. One person told us, "I have been asked questions that they've told me are for my care plan." One relative said, "I had a meeting last week in terms of mum's care plan review and it was a relief to have this meeting, it being the first since mum went to live there."
- No new people had been admitted to the service, so we were unable to check any new pre assessments.
- Records relating to showers had improved.
- One person told us, "If I wanted to go out for new shoes or clothes, I would ask a carer and then a date would be arranged as soon as possible."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The manager understood the need to ensure people were able to access information in a format suitable for them. The manager told us they can communicate using picture cards, iPads, writing on notebooks and they could obtain information in large print should this be required.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We saw an improvement in the activities being offered and feedback about activities was positive. The service had 2 activities co-ordinators who planned and led on a variety of activities for people living in the home.
- People and relatives told us activities had improved. Relative comments included, "Two people are doing activities in the home now and there's something on every day. It's good that there are armchair activity sessions too.", "[staff member] is the activities' coordinator and there's much more going on now." and "They have developed many more activities, which are very good and [staff member] is completely committed to her job, and she is so enthusiastic." One person told us, "There are activities now, which are good. We have conversations too downstairs in the lounge which I enjoy."
- On the day of our inspection we witnessed a valentine's day lunch taking place, people were engaging in this activity, and staff were encouraging people to get involved.
- People were supported to have visits from their loved ones.

End of life care and support

- No one was in receipt of end-of-life care at the time of the inspection.
- People's end of life care plans were in the process of being implemented.
- The service had an end-of-life policy in place, which detailed the expectations around end-of-life care.
- Since the last inspection the service had put an end-of-life champion in place, but staff had yet to complete end of life training.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection the provider had failed to ensure audits were sufficiently robust to identify the shortfalls found. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider's oversight of the service was ineffective. Systems were not in place to support the monitoring and improvement of the service.
- Continuous learning and improving care was not consistently taking place. The manager had implemented a number of audits since starting in their role, but these needed to be more robust to ensure they identified issues such as those we found during the inspection. When lessons learned were identified by the manager these were recorded.
- Some concerns we identified during the last inspection had not been learned from.
- The service was unable to provide evidence of quality assurance checks being completed by the provider.

The provider had failed to ensure good governance. This placed people at risk of harm. This was a continued breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Poor governance concerns had been identified on our previous 2 inspections.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to ensure systems were in place to ensure notifications were submitted. This placed people at risk of abuse. This was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

- Although management were reporting necessary safeguarding concerns, we found 2 incidents which had

not been reported to CQC when they should have been.

We found no evidence people had been harmed as a result of us not being notified. However, systems and processes were not being followed to ensure notifications were always being submitted when needed. This placed people at risk of abuse. This was a continued breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

- The manager was aware of their responsibility under the duty of candour and spoke about being open and honest when things go wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure systems were either not in place or robust enough to demonstrate records and governance was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- We were encouraged to return to the home to see the improvements made within the service, unfortunately we did not observe enough significant improvement to remove a number of the breaches. Whilst there were improvements in some areas, a number of concerns noted on the first inspection had not been acted upon.
- Various records were not in place as documented throughout this report.
- The provider had not returned a completed PIR following this information being requested. At the last inspection, we were asked for an extension, but the information was still not received.

We found no evidence people had been harmed, however, systems were either not in place or robust enough to demonstrate records and governance was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service did not have a registered manager in post. The previous registered manager de-registered in March 2022. Since the last inspection the previous manager had also left post and a new manager had been appointed in August 2022. An application has recently been submitted for this manager to become registered.
- Following the failings at the last inspection, we imposed 2 conditions on the providers registration. One condition required the provider to submit monthly medication audits completed by a qualified and competent professional. The other condition required the provider seek CQC authorisation on admissions or re admissions to the home. We identified 1 person had been re admitted to the home without authorisation, and we had only received 4 medicines audits when we should have received 6. Therefore, we found the provider had not fully complied with these conditions.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager was working to improve outcomes for people.

- People completed a questionnaire with the activities coordinator in January 2023, the results were awaiting analysis. Staff surveys were sent out in January 2023, these results had been analysed and were mostly positive. Relatives' surveys had recently been sent out and they were awaiting return, though some relatives told us they had not received these. In response to this, the manager told us the service only sends communications to the next of kin.
- Relatives comments were mostly positive, but they felt that communication could be improved. Their comments included, "It (the home) seems to be well managed now. There had been no meetings or questionnaires though. Possibly these new managers are waiting to make improvements before they call a residents' meeting or send out questionnaires. There are no newsletters sent out, or information and feedback in any format other than via the new Facebook group, which is regularly updated." And "There seems to be a lack of general communication. Meetings and a monthly newsletter are planned though."
- The frequency of the staff meetings had improved since the last inspection. Staff told us they enjoyed their jobs and their comments included, "Yes (it is a good place to work). Because everybody is more upbeat, as management treat people fairly. They are making the right changes, though I am bias as I have always enjoyed this job even when it wasn't good." And "Yes (it is a good place to work). I like everything about it, I love the residents, I love coming to work, the residents are happier."
- People spoke positively about the new management, comments included, "The manager is very approachable and listens to me" and "This is a good home, and it seems to be well managed now."
- The service worked in partnership with the local authority and various health teams.