Dr A Subramanian and S Kardarshi

Lyndhurst Residential Home

Inspection report

20 Oxford Road
Dewsbury
West Yorkshire
WF13 4JT

Tel: 01924459666

Date of inspection visit:
27 July 2016
28 July 2016

Date of publication:
22 September 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 27 and 28 July 2016. Day one of the inspection was unannounced; day two was announced. We last inspected Lyndhurst Residential Home on 25 November 2013 and found it was meeting the legal requirements we inspected against.

Lyndhurst Residential Home is a residential care home in Dewsbury. The home provides accommodation, personal care and support for up to 15 older people, some of whom are living with dementia. Accommodation at the home is provided over two floors, which can be accessed using a stair lift. Eleven rooms are single occupancy and two rooms are shared, accommodating two people in each room.

At the time of the inspection there were 15 people using the service.

A registered manager was registered with the Care Quality Commission at the time of the inspection however they had left the organisation and had not been managing the service since 17 December 2013. The current manager had been in post since then as acting manager and subsequently as the manager but they had not registered with the Care Quality Commission.

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.

During this inspection we found the registered provider had breached regulations in relation to safe care and treatment, staffing, good governance, person centred care and dignity and respect. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Medicines were not managed safely. There were no risk assessments or care plans in place, nor were there any guidance documents for staff to follow when administering 'as and when required' medicines such as diazepam or paracetamol. Staff made decisions as to whether people should be given a medicine used in the management of diabetes based on the amount they had eaten. This had not been agreed with people's doctors. There was no system for checking the temperature of the medicine fridge or medicine cupboard, and liquid medicines did not have an opened date recorded on them. This meant medicines could be stored at the wrong temperature and be administered after the 'discard by' period. The medicine fridge was not locked and was in an area used by people and visitors.

Staff told us there were not enough staff to meet people's needs. Some people needed two to one care and this meant whilst staff were supporting them, there was no one available to support other people unless the assistant manager or manager were on the floor. Care staff were also responsible for engaging people in activities, doing the laundry and preparing people's tea as the cook finished work at 2pm. The manager

agreed with our observations that there were not enough staff.

There were concerns in relation to fire safety which were passed on to the fire service. This included fire doors not closing properly, no evacuation aids to support people to who lived on the first floor and a fire exit leading to a gate which was locked with a padlock.

There were no premises risk assessments or emergency contingency plan. There was also no evidence of an electrical installation condition report having been completed at the service. Evidence of portable appliance testing (PAT), gas safety check and lifting operations and lifting equipment regulations (LOLER) could not be found at the time of the inspection however they were submitted at a later date.

Staff had not had an annual appraisal nor did they receive regular supervision. Training records showed that staff had not received appropriate training to support them to meet people's needs.

Some people had authorised Deprivation of Liberty Safeguards (DoLS) in place but one person's care records stated they did not have capacity to make decisions and a DoLS had not been applied for. The assistant manager confirmed this should have been addressed.

There were two shared bedrooms at Lyndhurst residential home. These were occupied by people who did not have capacity to make this decision, but there were no recorded best interest decisions in place to support the decision that they should share a room.

Dignity and privacy was not always respected as there were no care plans in place in relation to the specifics of maintaining privacy whilst people shared a room. We saw two people's prescriptions were pinned to a noticeboard in the dining area and care records were not stored securely.

Care plans did not detail strategies for staff to follow in relation to managing behaviour that challenged, nor did they detail how to support people with mobility needs. Information was vague and stated, 'assist with personal care' but there was no detail on the exact nature of the support people needed. There was no information on people's preferences or social history and background.

People were supported to access healthcare professionals, however where professionals had made recommendations in relation to people's care and support this was not always included in care plans.

There was no effective audit or quality assurance system in place to identify areas for improvement. None of the concerns noted during the inspection had been identified by the provider.

Staff knew people well and engaged with them in a respectful, caring and compassionate manner. Recruitment practices included an interview, two satisfactory references and the receipt of a clean Disclosure and Barring Service (DBS) check.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Medicines were not stored, managed or recorded in a safe way.

Risk assessments did not effectively assess and mitigate risks to people.

There were no risk assessments in relation to premises safety.

Staff told us there were not enough of them to support people appropriately.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act (2005) had not always been followed.

People had their liberty restricted but there was not always an authorised Deprivation of Liberty safeguard in place.

Staff had not had appropriate training, supervision and appraisal.

Is the service caring?

Requires Improvement

The service was not always caring.

Confidential and sensitive information was on public display on a notice board.

People's privacy and dignity was not always respected.

Staff knew people well and had developed warm and caring relationships with people.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not person centred. There was no information about people's social history or personal background.

Care plans did not contain detailed support strategies to enable staff to provide consistent care and support to meet people's needs.

There was no evidence that people, and their family members had been involved in care planning.

Is the service well-led?

Inadequate

The service was not well led.

There had not been a registered manager in post since December 2013.

The provider had failed to ensure the required notifications were submitted to the Care Quality Commission.

There were no effective audit and governance system in place.

Lyndhurst Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 and 28 July 2016. Day one of the inspection was unannounced. This meant the provider did not know we would be visiting. Day two was announced.

The inspection team was made up on one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team, the safeguarding adult's team and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spent time with four people living at the service and spoke with one visitor. We also spoke with the assistant manager, three senior care staff, one care staff and one domestic. The manager was on annual leave at the time of the inspection so we were supported by the assistant manager. We spoke to the manager on their return from annual leave.

We reviewed three people's care records and five staff files including recruitment, supervision and training

information. We reviewed medicine records for four people, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We looked at the staffing levels at the home. The assistant manager explained that a formal staffing tool was not used. They said, "Staffing is based on the care plan needs." We viewed care plans and found no evidence of how people's needs related directly to staffing levels. There was a policy on 'staff ratio to clients' which was not dated, but there was a hand written entry dated 27 October 2010 to say it had been updated. This policy stated, 'It is legislation that for fifteen clients the law states that we have to have two carers on duty twenty four hours a day, seven days a week.' There was no reference to which legislation stated this. The policy stated if there was an emergency 'the domestic is the first person to change roles and cover the care.' We asked the domestic if they completed any care and they said, "No, I'm just the domestic."

The assistant manager explained that ordinarily they helped with support at key times during the morning and at lunchtime. During the afternoon there were two care staff and at night there were two care staff with a staff member on call. We asked how many people needed two to one support and who would support the other fourteen people whilst staff were supporting them. The assistant manager said, "No one would support the other people, especially on an evening." Care staff were also required to manage people's laundry, provide meaningful activities and prepare tea for people as the cook left at 2pm.

We spoke with staff about whether they thought there were enough care staff to meet people's needs. One staff member said, "I don't think so, not enough staff. Some days are fine, it depends on people getting up and how they are." They went on to say, "From two o'clock following handover we can sometimes spend one to one time with people but it's combined with personal care." Another two staff members said they thought there were not enough staff when only two staff were on shift. One staff member said, "No, there's not enough staff to support people as they need to be, we need to be able to spend more time with people." They added, "Normally the manager or assistant stay on the floor in the morning to help out but from two to eight is the most difficult time, we do activities, drinks, snacks, tea time and laundry." Another staff member said, "[Person] gets really anxious if staff aren't with them, there's a real impact if someone has a fall. [Person] had a fall last night and another person came to tell us. There's four people who need two staff." They added, "[Person] follows staff, [person] wanders, one to one time is missing, we do the laundry and extra cleaning, we've no dementia training."

We received differing opinions on the number of people who needed the support of two staff to provide their care. Some staff told us three people, others said four.

We spoke with the assistant manager about our observations that support was task driven as staff did not have the time they needed to spend with people. They said, "I agree on an afternoon. We discussed putting a routine in place, serve dinners first with one carer in the dining room, the other carer does drinks and washing up while I do the meds." They added, "I do know what it's like, we need someone else at the busy times." We spoke with the manager about staff telling us they did not think two staff were enough, the manager said, "I'm in agreement with that."

This was a breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations

2014.

We looked at how medicines were managed within Lyndhurst Residential Home.

Medicine administration records (MARs) were used to record the administration of medicines. There were no gaps noted but handwritten entries on the MARs had not been countersigned or checked for accuracy. This meant there was the risk of error as there was no clear line of accountability for changes which put people at risk of not receiving the correct medicines. Handwritten entries should be checked and signed by a second trained staff member in line with the National Institute for Health and Care Excellence (NICE) guidelines. We also saw entries where metformin, which is used in the management of diabetes, had not been administered and the notes stated, 'not given as not enough eaten.'

We observed staff administering medicines at lunchtime. One person was told by staff, "You can't have your metformin as you haven't had enough to eat." There was no guidance recorded from the person's doctor as to the amount of food the person needed to eat before they had their medicines. We spoke to the assistant manager about this who said, "Oh, [staff member] also has diabetes and it's what their doctor told them so we follow that." The manager confirmed this to be the case. The information on the MAR chart was to take 'with or just after food'; there was no specification about the amount of food that needed to be eaten before the medicine could be administered. This meant people were at risk as medicines were not being administered as prescribed.

Liquid medicines and eye drops were not dated on opening. Some medicines had instructions that they should be discarded four weeks after opening. We asked staff about this, one staff member said, "We weren't told to date things in our training." This meant people were at risk of receiving their medicines after the discard by date. Temperature checks had not been completed of the medicines cupboard. One staff member said, "We don't do temperature checks." They added, "Any [medicines] that say store in fridge are in the fridge." We checked the fridge and noted the temperature had not been checked since May 2016. This meant we could not be sure medicines were stored within the recommended limits for safe storage. Also, the medicine fridge was not locked and was accessible to people and visitors.

One person received their medicines covertly, that is, hidden in food or fluid without their knowledge. This had been agreed by the person's doctor as an appropriate procedure which was in the person's best interest. A risk assessment had been completed and evaluated on a monthly basis, however there was no care plan in place to guide staff on how to administer the medicine covertly, for example in a yoghurt.

There were no care plans or risk assessments in place in relation to supporting people to take their medicines. Where people were prescribed 'as and when required' medicines there was no protocol in place to guide staff as to when this should be administered. This meant there was no guidance for staff to follow in relation to dosage, time between doses and indications that a person may need their medicine. It is important staff have this information for people who may not be able to communicate their needs fully. This meant we could not be sure 'when required' medicines were administered safely.

Some risk assessments were in place, however they did not always have associated care plans, nor were they always up to date and accurate. For example one person had a risk assessment for verbal and physical aggression dated March 2014, however there was no specific care plan in place for managing any aggression. The risk assessment stated, 'When agitated a member of staff to have [person] in sight at all times.' Given that there were two care staff on shift at any given time this meant if staff were observing this person there would only be one other staff member available to support 14 people, some of whom needed two staff to support them. The risk assessment also said, 'Work in pairs for personal care where possible.'

One person's care plan stated male staff were not to provide support with personal care, so on days when there was only one female member of staff on shift the person would either not receive personal care, or the female member of staff may have been placed at risk by supporting the person on their own.

One person had a risk assessment dated February 2014 in relation to, 'over friendliness to males.' There was no associated care plan in place to provide guidance to staff on how to manage this behaviour.

We saw another care plan stated a person required the support of two staff and a hoist to transfer. There was no risk assessment in place in relation to mobility or moving and handling. The assistant manager said, "Only one person needs a hoist and it's only used when we lift them off the bed so we can clean the mattress."

A mobile hoist was stored on the first floor. We asked the assistant manager who used the hoist. They said, "No one does routinely, [person] uses it when we clean the mattress." This person resided in a ground floor room so we asked whether there was a hoist downstairs as there was no lift in the building. The assistant manager said, "No, the handyman carries it down the stairs." This placed the person and anyone else on the stairs at risk, especially as there was a chair lift on the stairs to manoeuvre around.

We asked about environmental risk assessments in relation to managing and maintaining the premises safely. The manager said, "There are no health and safety assessments." We asked the assistant manager for certificates in relation to the electrical installation condition report. This could not be found during the inspection. We spoke with the manager about it and they said, "What's one of those." We also asked to see evidence of a gas safety certificate, portable appliance testing (PAT) and lifting operations and lifting equipment regulations (LOLER) certificates, but these could not be found; they were submitted following the inspection. We asked if there was an emergency contingency plan in place for staff to follow if the building was not habitable or if there was a staffing crisis. The assistant manager said, "Oh, it used to be [other care home] but that closed." We asked if there was a documented plan and they said, "No."

A fire evacuation procedure was in place and was reviewed on an annual basis. We asked staff about the procedure if the fire alarm went off. One staff member said, "I would get everyone into the main car park at the back." We asked if they completed simulated drills to ascertain the time it would take to evacuate people, they said, "No, no simulated drills." We asked if there was an evacuation chair to support the evacuation of people from the first floor if they had mobility needs. They said, "I don't know if we have one. The safety compartments last half an hour and I know where the compartments are so we would move people two compartments away from the fire." Fire drills had been completed until April 2016. After this date no drills were recorded.

During the inspection it was noted that some of the fire doors into people's bedrooms were not closing fully, nor was the fire door on the first floor corridor or one of the ground floor lounges. One fire door had no intumescent strip fitted which meant it would not provide protection in the event of a fire. This meant people would not be provided with the 30 minutes of protection given by appropriately fitted fire doors. A fire door monthly test record had been completed each month from January 2016 until May 2016. The only faults recorded related to door guards which had been replaced. There was no information in relation to whether the doors were closing appropriately.

We noted if people exited the building by the front door there was a gate which was padlocked. We spoke to the manager about this who said, "The key dangles on a rope on the gate so people who have capacity can open the gate." We asked if this could be used as a fire exit, they said, "Yes." The padlocked gate presented a potential risk as people may have become trapped due to not being able to unlock the padlock.

Personal emergency evacuation plans (PEEPs) were in place and recorded people's room number, the fire zone they lived in and the time taken to evacuate each person. Some personalised information was recorded such as, 'needs a minimum of two staff to move to safe area.' There was no information on how to move the person to the safe area. We noted none of the PEEPS were signed or dated.

We saw a '2016 environment development plan' was in place with timescales for works to be completed until 31st July 2016. Two rooms had been ticked as having had the works completed, however the other four areas for action had not been ticked as done. These included seven rooms needing repaired or replaced vanity units; another room needing a ceiling painted and the vanity unit repaired or replaced. There was a hand written addition which stated, 'The remaining four toilets, the sluice will be looked at for new floors and décor at the end of July.'

The office was situated in a basement with the laundry area and was accessed via a steep set of stairs, which had not been risk assessed. This area was only accessible to staff via the use of a key code. The area was in a state of disorganisation, there was no flooring, there was a malodour and it was in need of cleaning due to the environment being dusty. The manager explained the office was disorganised and dusty due to a new floor being fitted.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Any situations which were felt to be of a safeguarding nature were reported via a telephone call to the local authority safeguarding team. The assistant manager explained the procedure to be, "We phone Gateway to Care, tell them the incident and they advise on what to do, for example if the person needs one to one care or if we need to review the person's needs." They added, "We have never had a situation where we were concerned about staff." We asked what the procedure would be if there were concerns about a staff member's behaviour. The assistant manager said, "It's instant dismissal. We would investigate record, take statements and until investigated the staff member would leave the building. We would phone Gateway to Care."

Any records in relation to safeguarding concerns were kept within people's care records so there was no overall analysis to look for trends or lessons learnt. The manager said, "We need a new system." Accidents and incidents were also recorded in people's care records. We saw no evidence of any analysis of accidents of incidents for triggers or lessons learnt.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff files evidenced recruitment practices involved an application form and interview followed by the receipt of two satisfactory references and a disclosure and barring service (DBS) check. DBS checks are used as a means to check whether applicants had a criminal record or were barred from working with vulnerable people. We asked whether DBS checks were renewed and the manager said, "No, but we do have some staff who have been here 19 years." They added, "We should start and redo them."

We saw a cleaning schedule had been introduced for deep cleans of bedrooms however the communal areas were not cleaned as part of a scheduled programme. One person said, "It's lovely and clean and tidy." One domestic said, "We have all the equipment we need, we see the manager if anything breaks and it's sorted." They added, "I've done infection control training, we just did an in house session on infection control."

We saw a communal laundry basket was stored in a passageway accessible to people and visitors. We spoke with the assistant manager about this in relation to infection control, they said, "Oh yes, I see what you mean."

Inadequate

Is the service effective?

Our findings

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 application 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.

We found some people's liberty was being restricted. For some people the requirements to submit applications to the supervisory body for authority to restrict people's liberty had been followed.

For one person we noted care records stated the person did not have capacity. The care record read, '[Person] is unable to make any of [their] own decisions. [Person] is unable to retain any information that is given to [them]. [Person] would need the full assistance of family and MDT to help make any decision that would mean changes to lifestyle. There were no mental capacity assessments in place, nor had a DoLS application been submitted. This person received care and support in a way that restricted their liberty.

Lyndhurst Residential Home has two shared bedrooms. Three of the people who were sharing rooms had authorised DoLS in place. The care records for the other person stated they lacked capacity to make decisions. We discussed this with the assistant manager who said, "I agree [person] is deprived of liberty." We saw no application had been made for a DoLS. This meant the person was potentially being unlawfully deprived of their liberty.

There was no evidence of recorded mental capacity assessments or best interest decisions to support the decision that these people should share a room. The assistant manager said, "I wasn't aware we needed it." There was no information in people's care records in relation to people residing in shared rooms.

Relatives were signing to give consent to care and treatment when they did not have lasting power of attorney for health and welfare.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence that staff had attended training in mental capacity and DoLS. One staff member said, "Mental capacity is about the ability to understand or not understand. We would assist people to

understand things by prompting." Another staff member added, "If people don't have capacity they might need a DoLS."

One staff member said, "I've done infection control, first aid, end of life, safeguarding, DoLS, medication, moving and handling, health and safety and fire training." We asked if they had completed any training in relation to dementia care, they said, "I've looked on the computer on my own but no training session as such." Another said, "I've done meds, infection control, NVQ, fire, first aid, moving and handling, no DoLS training [manager] explained it and no safeguarding training." We viewed training records which showed this staff member had completed safeguarding training, but there was no evidence that any staff had completed mental capacity and deprivation of liberty safeguards training. Another staff member said, "I've done safeguarding, infection control, fire, moving and handling." We asked staff if they had completed any training on supporting people living with dementia, staff told us they had not.

We noted care staff prepared the evening meal for people as the cook finished work at 2pm. We asked the assistant manager if care staff were trained in food preparation and hygiene. They said, "None of the care staff have it." Training records showed one of the cooks had not attended food safety training. All other food safety training had been attended in 2012, and had been completed by 20% of care staff.

We viewed training records for 2015 and 2016. Records for 2015 showed that out of 20 staff 15% had attended medicine training. Records for 2016 showed that this had increased to 60%. We spoke with the manager about this who said, "We have done the training but are waiting for our certificates."

There was no evidence that staff had completed training in dementia care, care planning or risk assessment.

We spoke with staff about supervision and appraisal. One staff member said, "I am supported, the manager's on the floor." We asked about one to one meetings. They said, "We do, but I don't think they are recorded. There's plenty of opportunity to share, we are a very open team." We asked if they had received an annual appraisal and they said, "Oh, yes that's done." Another staff member said, "Oh yes, supervision, I think it's every 12 months, or maybe every six." We asked if they had an annual appraisal, they said, "With [manager], they just make a few notes."

The manager said, "I do supervisions every three to six months, I'm about half way through them. I know when something's wrong with my staff so I talk to them then. They talk to me every day so by the time we get to supervision we've dealt with it." We asked about annual appraisal and they said, "No, they haven't been done."

We asked the manager about induction for new staff. They said, "It's a tour of the building, fire exits, they do workbooks, training and shadow staff." We did not see any recorded evidence that staff had completed an induction.

This was a breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held every two months from January 2016 to 4 May 2016. Discussion included records not being completed in full in each of the last three team meetings. The team meeting file in the service held minutes of meeting for August 2014 and February 2015; minutes from the more recent meetings were not available in the file for staff to read.

We looked at how people's nutritional needs were met. One person said, "I like my food, thank you." Another

person said of their breakfast, "I enjoyed it." The meal choices were written on a chalkboard in the dining room and the cook spoke to each person in the morning to see what meals they would like for the day.

There were no menus on tables nor was a pictorial menu available to support people living with dementia to make a choice. We observed staff reminded people at tea time what the options were and when some people said they did not know what 'angel delight' was staff brought it to them so they could see what it was. This supported people to make decisions about their meal.

People were offered drinks on a regular basis and could choose between hot and cold beverages. Meals were hot and nutritious and people were offered a choice in the morning of what they would like for lunch and tea. At mealtimes we observed staff reminded people what they had chosen but if they didn't want it staff offered alternatives.

People were encouraged to eat their meal. This involved staff encouraging people by saying, "Are you going to eat your meal or would you like something else?" Other people were asked if they needed support with cutting their food. We observed staff asked permission before moving someone's plate around to make it easier for them to eat their food, and one person was physically supported with putting food on their spoon. Staff were discreet in the support they provided and always asked permission before providing any help.

People's care records showed they had access to healthcare professionals such as the district nurse, doctors, opticians, and dieticians.

Only one bathroom was available for people to use on the first floor of the building, which was accessible by a stair lift. There was an additional bathroom on the ground floor which was being renovated. We asked if people had access to a shower but were told there was no facility for people to enjoy a shower. We also noted there were not enough tables and chairs in the dining area should everyone choose to have a meal in there at the same time.

Many of the people living at Lyndhurst Residential Home were living with dementia and were disoriented to time and space. We did not see any dementia friendly signage, nor had the environment been adapted in any way to support their needs.

Requires Improvement

Is the service caring?

Our findings

We spent time with people in communal areas observing care and chatting to people.

We noted two people's prescriptions were pinned to a notice board in the dining room so people's confidential and sensitive information was on display for anyone to see.

Care records were stored in a cupboard in the dining room. The cupboard was closed with a latch but it was not secured with a lock so records were accessible to anyone who opened the cupboard.

There were two shared rooms, each of which accommodated two people. Care plans did not reflect the shared living environment and therefore there was no guidance for staff on maintaining the confidentiality, dignity and respect of people whilst they were receiving care in their room. We noted one person who shared a room received visitors who spent time with the person in their room. This meant the other person either needed to vacate their room or be present whilst the other person spent time with their family.

One staff member referred to people as 'feeders.' We saw care plans referenced people, 'rowing with fellow residents' and being 'overly loud.' Another care plan advised staff to wait until the person's mood was 'not as dark.' The language used was not respectful of people's needs.

This was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

One person we spoke with said, "I like the girls they are lovely. I'm very happy." They added, "Thank you for looking after me." Another person said, "They are good lasses, they do a good job." Another person said, "The staff are right nice, the odd one's a bit grumpy." A relative said, "It's a really homely home."

One staff member said, "I absolutely love it here, it's about the clients, the age of them. I see what they have done for us and I'm attached to people."

We observed care staff spoke to people with kindness and compassion. They knew people well and referred to people by their preferred name. Staff involved people in conversation and used their knowledge of people's history to start a conversation. For example they spoke with one person about their previous job in the mills and to another person about their love of Blackpool or their favourite music.

One visitor told us they thought the staff were caring but they said, "I don't always know about falls, or health needs. I didn't know [family member] was in hospital. I am happy with the way they manage [family member's] health but communication could improve." The person discussed this with the assistant manager.

We did not see any information on display about advocacy services, however where the involvement of an independent mental capacity advocate (IMCA) was required in relation to DoLS applications this had been

arranged.

Inadequate

Is the service responsive?

Our findings

We looked at care records for people living at Lyndhurst Residential Home to ensure staff had the guidance they needed to support people in a personalised and appropriate manner. We found care plans were not personalised, they did not provide staff with the relevant information for them to support people safely and appropriately, and they did not contain detailed strategies. Care plans had been written in February 2014 and contained monthly care plan updates however changes in people's needs had not prompted a new care plan to be written. Handwritten additions had been made to care plans and in some records information had been crossed out. This meant care plans were disorganised and chaotic. It was difficult to identify people's current needs and to assess if the information was accurate and current.

One person's physical wellbeing care plan had been written in February 2014 and stated, 'staff to offer sugary content food/fluid if [person] shows signs of low sugar – see risk assessment. Staff to follow dietician's advice re diet.' We did not see any specific advice from a dietician recorded in the care plan, nor were there any symptoms of low blood sugar recorded. There was no information in relation to the testing of this person's blood sugar levels or whether it was required. The care plan had an update sheet which had entries every month, some of which stated, 'no change.' Other entries recorded information about weight loss and sleep pattern, there was also reference to the person having 'fortified desserts and crèmes' but this information had not led to a new care plan being developed.

A personal care plan recorded all the areas of personal care one person was 'non-compliant' with. The care needs were recorded as, 'One carer to run [person] a bath and try to coax [person] in until the bath is cold and cannot be used.' There was no detail on how to encourage and support the person, what their preference was in relation to the time they bathed, or whether they enjoyed a bubble bath or particular products to be used. We noted this person had only had one bath in July and only strip washes through June. This person's risk assessment for personal care had an entry dated 27 July 2016 which stated, '[Person] is still compliant to personal care.'

Communication care plans stated staff should 'divert' and 'intervene and distract when rowing with fellow residents.' There was no information for staff to follow in relation to when to offer support or how to divert, intervene or distract the person.

Another person's personal care plan stated two staff were needed to assist for all washing, dressing, bed bath, oral care and hairdressing but there was no detail on how staff should assist the person to meet their needs, other than, 'Use a toothbrush, clean [person's] tongue and freshen mouth.'

Where specialist pressure relieving equipment was used such as airflow mattresses there was no detail on the setting that was required, other than to say it should be, 'set correctly.' If people used continence aids there was no detail on the products used other than stating the person used pads.

One person had a mobility care plan which stated they were transferred with two carers and the hoist but there was no information on the sling that should be used or detail on how to support with transfers. We

asked the assistant manager about this who explained the hoist was only used to lift the person from the bed so the mattress could be cleaned. We noted there was no other detailed information from a health professional with regards to the person being cared for in bed. We spoke with staff about this person's care. One staff member said, "They are turned every two hours and don't have any pressure sores." We did not see any detail in care plans on the frequency the person needed to be turned.

Another person's movement and handling care plan stated they needed, 'One/two carers to assist in all transfers.' There was no detail for staff to follow on how to transfer the person or any equipment needed by the person.

This was a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

There was no information available in relation to people's social history or personal background. There was no evidence in care records that people and their family members had been involved in assessing their needs and developing care plans. There was no information on people's preferences as to how they wanted to be supported or cared for. One visitor said, "When [family member] first moved in a social worker was involved and we had a meeting about needs. I'm not sure if we had any involvement in care plans. There was only the initial review that I've been to."

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We looked at complaints and how they were managed. One relative said, "I don't recall having information on how to complain but I would speak to the manager." They added, "I've never had reason to complain." One person said, "I've no complaints, I would speak to the staff."

A complaints file was in place however it was empty. The assistant manager said, "I'm not going to lie to you, it's an area we need to work on. We haven't had any complaints though. We did a relatives survey and comments were positive."

We saw relatives' surveys had been completed and the manager had responded to each survey individually. There was no overall analysis of the survey but feedback was generally positive. Compliments were recorded and included comments such as, 'thank you so much for everything,' and 'many thank yous for the years of care you gave our [family member]. I don't recall [family member] ever complaining about the staff and they spoke fondly of many, especially the cook."

We asked the assistant manager about staff surveys, but these were not completed.

We looked at the activities that were available for people to take part in. The assistant manager said, "They (activities) are on an afternoon when it's quiet. Things like dominoes, western films, chatting, we go to the park. We raised £750 from a summer fayre and people were involved with the stalls. [Person] enjoys gardening." Activities were managed by the care staff as there was no activities co-ordinator in post. There were no activities advertised but we did see the local church hold a church service during the inspection. We also saw two people playing dominoes with a member of staff and one person was cleaning their fish tank. The assistant manager went on to say, "I like to take the younger end to the pictures, we went to see Dad's Army." We asked about specific activities for people living with dementia, they said, "There's nothing dementia specific, we tend to give them more one to one as obviously they can't focus on tasks. We use reminiscence cards so they can understand more, old time music, dancing." An activity file contained an

activity sheet which listed bath, nails, taken to smoke, bingo, music, movie, dominoes, nails, creativity, baking, armchair exercise, and reminiscence.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection a manager was registered with the Care Quality Commission, however the current manager confirmed they had left the service in December 2013. The current manager had been in post at that time, as acting manager and subsequently as manager. The existing manager has not yet made a successful application to register with the Care Quality Commission.

Providers are required to submit notifications of absence, changes, deaths and other incidents to the Care Quality Commission. We viewed an admission and discharge record and noted there had been three deaths which had not been notified to the Commission. We saw five DoLS applications had been submitted to the supervisory body but the Commission had not been notified of the outcome of these applications. The provider had also failed to notify the Commission of the absence of the registered manager in December 2013.

We asked the assistant manager about audits that were completed. They said, "I do care plan audits and we do medicines audits. I think the manager does some but I don't have access to them." The care plan audits detailed the person's name and a date each month. There was no detail on the documents that had been audited or on any action that was needed to improve the quality of information. We asked the assistant manager about there being blanks next to dates. They said, "That means no actions have been identified." Care plans were not always complete or legible and it was difficult to assess if the information was accurate, complete and up to date.

Before the inspection the manager submitted a provider information return. They said of improvements in the safe domain, 'In the next 12 months we have to no set plans, when an area Is highlighted as needing improvement we put measures into action, when the need is around safety we action measures immediately.' There were no actions in place to address the concerns for safety noted during this inspection.

The medicines audit was a record of a stock check. Medicine administration records had not been audited for completeness or accuracy. The manager said, "I do check care plans and medicines but the problem is there's no paper trail."

There were kitchen and cleaning schedules in place but neither the assistant manager nor manager maintained oversight of the schedules to ensure work had been completed to a satisfactory standard.

Systems and processes failed to assess, monitor and improve the quality and safety of the service provided. Risks relating to care, health, safety and welfare of people, staff and visitors had not been effectively identified and in respect of premises safety no risks assessments had been completed. The provider had failed to ensure effective audit and governance systems were established and implemented.

Safeguarding concerns, and accidents and incidents were recorded, but there was a failure to analyse the information for lessons learnt or triggers. This meant risk was not being assessed, nor could it be mitigated for.

The assistant manager and manager acknowledged, and agreed with the concerns noted during the inspection, however their audits and systems had not been effective in recognising action was needed to improve the quality of the service provided.

We saw a manager's weekly report was in place which recorded information in relation to occupancy, visits by the contracts team, complaints or concerns and an update of action taken. These were last completed in January 2016 and when they were completed all the information was blank aside from any changes to occupancy.

We saw no evidence of provider visits to assess and monitor the quality of the service, nor did we see evidence of meetings between the provider and the manager to discuss quality and improvement.

Various policies and procedures were in place, however there was not a robust procedure for review and version control. The 'safe handling of medicine' policy was not dated and there was no reference made to MCA (2005) and the administration of covert medicines. The recruitment and selection policy was dated 2009, there was a policy review date recorded as June 2010 and October 2010, since then a date and initials had been added on an annual basis since 2014 however there were no updates so we could not assess if the policy and procedure reflected current guidance and legislation in relation to recruitment. The accident procedure was dated February 2008 and had incorrect information as it stated the Care Standards Commission should be notified if a person was admitted to hospital. A policy in relation to the 'death of a client' was in place and was dated February 2008. A handwritten entry in 2010, 2013, 2014, 2015 and 2016 stated it had been updated, however there was no reference to Deprivation of Liberty Safeguards and the requirements to notify the coroner of a death if a person was subject to an authorised DoLS.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The manager's office was not directly accessible to staff due to being in the basement area so the manager was not able to directly observe and manage care and support from their office. There was no private space (aside from the basement) for relatives to meet privately with the manager or care staff aside from their family member's room or the communal lounges.

Staff told us team meetings were held and they felt able to add agenda items for discussion. One staff member said, "The manager is supportive, they know everyone well." Another said, "It's a good staff team, they are supportive. The staff rally round to support each other and to cover any shifts."