Lyndhurst Rest Home Limited

Lyndhurst Rest Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 21 and 22 March 2018 and was unannounced.

Lyndhurst rest home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lyndhurst can accommodate 44 people.

Accommodation is spread over 3 floors in a large and extended detached property, overlooking the seafront at Tankerton, with many rooms benefiting from this position. There were 2 dining rooms and 2 communal lounge areas where people could choose to spend their time.

The service did not have a registered manager in post. The last registered manager left the service in December 2017. A new manager was appointed shortly after; however, they have since left. 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.

Lyndhurst was last inspected September 2017. At that inspection it was rated as 'Inadequate' overall. A number of breaches of Regulation were found during that inspection and the service was placed into special measures.

At this inspection, although people and relatives gave some positive feedback about the service, and we found improvement in some areas; we continued to have significant concerns about the safety and well-being of people. Risks continued to be identified and a number of continued breaches of Regulation were found. The service remains in special measures.

Risks including those associated with medicines, risks to people's health and wellbeing including falls, eating and drinking, skin care, moving people and accidents and incidents had not been properly assessed or minimised in order to keep people safe. There had been improvements to the environment and recruitment procedures.

There were not enough staff to safely meet people's needs, the provider did not use a recognised tool to assess and determine safe staffing levels. Staff training had not been effective in some areas. Training with a new provider had been booked, however we were not able to make a judgement at this inspection on its effectiveness. There continued to be minimal evidence that lessons had been learned and improvements made when things went wrong. The new deputy manager and the provider's area manager had begun to carry out staff supervisions and implement competency checks.

People's healthcare was not always consistently and effectively monitored. Risk assessments and new care

plans were not always current; posing a risk that people could receive inappropriate care or treatment. Care plans had been written by a consultant and lacked person centred detail. End of life care plans required attention to ensure they were person-centred. The provider's management team were aware of this and told us about the plans they had to improve this.

The principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards had not been properly understood or applied in the service. The commission had not been notified of the outcome of all DoLS applications, as is legally required. The service had begun to notify the Commission of other incidents and events that they were legally required to and had displayed their CQC rating.

Complaints were not responded to and investigated effectively. There were times when people were not treated with dignity and their privacy was not respected. People's involvement in care decisions and planning was not clearly evidenced. There was little adaptation to the premises to make them suitable for those living with dementia, although we were told of plans to implement changes.

The service was not well-led. Issues raised at our last inspection remained unaddressed; the provider had been slow to ensure changes were implemented to address the identified shortfalls. Although there had been some improvements, the areas of highest risk had not been prioritised. Auditing had stopped taking place and as a result was not used to identify shortfalls or give the provider oversight of the service.

Staff were able to tell us how to recognise and report safeguarding concerns. However, in practice they had not consistently reported concerns to management.

People were offered a range of activities to participate in. Feedback was sought from people and their relatives, although this was not effectively used to drive improvements.

People had routine appointments with GPs, health and social care specialists, opticians, dentists, chiropodists and podiatrists. People told us that on the whole they enjoyed their meals and were supported to eat if necessary. Meals were not reflective of the displayed menu and were not based on people's choice.

Overall, staff were kind and caring and ensured visitors felt welcome. People were encouraged to remain as independent as possible. We received mostly positive feedback from the people and relatives about the service.

People, relatives and staff felt the new deputy manager was approachable and responsive. They were working with the provider's area manager as well as receiving input from the local authority and a range of visiting health professionals.

The overall rating for this service continues to be 'Inadequate' and the service therefore remains in 'special measures' whilst we continue our enforcement action. 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.

We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Risks to people had not been minimised. This included risks associated with medicines, choking, falls, moving people and accidents and incidents.

There were not enough staff appropriately deployed to meet people's needs.

There was a lack of learning from incidents.

Staff told us they understood safeguarding processes and how to operate them but there was insufficient management oversight and action to ensure staff knew their responsibilities in relation to keeping people safe.

Recruitment processes were adequately robust to ensure suitable staff were employed.

Environmental and equipment checks had been completed.

Is the service effective?

Inadequate

The service was not effective.

The service was not meeting the requirements of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

People's healthcare needs had not been consistently recognised or escalated.

The management of nutrition and hydration was not effective. Food and Fluid monitoring was not accurate.

Staff training had been booked for the coming weeks; as a result we were not able to make a judgement on its effectiveness in supporting staff to carry out their roles.

People received input from healthcare professionals.

Improvements to the environment had been made, although

there were minimal adaptations to aid those living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not consistently considered.

People's care needs were not consistently met, or considered with a person centred approach.

Overall, staff treated people with kindness and gentleness.

At times people's independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Changes in the format of care plans had resulted in them lacking in accurate and person centred detail.

End of life care planning continued to require improvement.

Complaints were not properly logged and recorded and investigations were not always effective.

There was a variety of activities for people to enjoy.

Is the service well-led?

Inadequate

The service was not well-led.

Many issues raised at our last inspection had not been fully addressed, with slow progress against the provider's action plan and the highest risks not being prioritised.

Audits had not been completed, resulting in a lack of oversight by the management and registered provider. The lack of auditing meant that shortfalls in quality and care were not highlighted.

There had been no registered manager in post since December 2017.

Staff said they felt comfortable with the new deputy manager. The area manager told us about their plans and direction for the service.

The provider displayed their rating and made most statutory notifications to the CQC.□	

Lyndhurst Rest 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 carried out in response to information of concern from a number of sources. We 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.

This inspection took place on 21 and 22 March 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the inspection was carried out by three inspectors.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with nine people who lived at Lyndhurst and observed their care, including the lunchtime meal, some medicine administration and some activities. We spoke with five people's relatives or friends. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with two care assistants, activities staff, kitchen staff as well as the deputy manager, the provider's area manager and the provider.

During the inspection looked at care records for 12 people. We also reviewed other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe. Comments included; "I couldn't wish for a better crowd, it was the best thing I ever did coming here", "I feel absolutely safe there is always someone around" and "More secure than the previous home I was living in". Relatives told us their family members received safe care. "She is safe here this is where she is happy" and "I think she is safe, we have great communication with the home. They ring straight away if she has a bump."

Despite receiving some positive feedback from people and their relatives we had significant concerns about the safety of the service in a number of areas.

At our last inspection staff had been observed by inspectors supporting a person to move with a hoist in an unsafe way. At this inspection we continued to witness unsafe moving and handling practices. One person was hoisted from a wheelchair which did not have the brakes applied. The wheelchair was moving about and would not have provided a stable base if staff had needed to lower the person back into it if any problems were encountered. Staff told us that sometimes they put the brakes on the wheelchair and sometimes they did not, in case they needed to move the wheelchair away quickly. The staff member leading this manoeuvre had received manual handling training the day before and later said that the trainer had told them not to apply wheelchair brakes when supporting people to move with a hoist. This person's care plan about mobility had not been updated since 2016; when the person had not required support to move with a hoist. There were no instructions for staff within the care plan to describe how to support the person safely.

At our last inspection, accident and incidents had not led to care plans and risk assessments being updated to ensure people received safe and appropriate care and treatment. There had been no improvement in this area at this inspection. Incident reports had been completed by staff and mainly referred to unwitnessed falls. Information about these falls had not been added into people's assessments to show that risk levels had increased and there were no specific falls care plans or risk assessments in care files we reviewed. Information about falling was documented in mobility or other care plans but did not provide a central recording point for the falls experienced by each person, so that increases in incidents became immediately obvious.

Actions to prevent recurrences had not always been documented in care files but the management team told us what was happening to minimise the risk of falls for some people. For example, some people's rooms were changed to ground floor ones for greater supervision and/or had special alarm mats in place to alert staff when the person was mobile. However, these actions had not proven effective because staff told us that one person moved the alarm mat to avoid stepping on it, which meant staff were not made aware the person was mobile. The management team told us that hourly checks were made on people during the night to ensure their safety. However, one person had been found injured in bed on an occasion when there had been an hour and a half between checks. This person was known by staff to walk around constantly and to sometimes do so overnight. Half-hourly checks had been put in place the following day and these showed that the person had been agitated, unsettled or walking about at every check from 4:00pm until 12:30am.

From 04:00pm until 08:00pm, when the night staff came on duty, staff recorded that one to one care had been given but from 8:00pm until 12:30am there was no mention of this on the check sheets, despite the person remaining agitated and unsettled. The management team told us that they were exploring other measures to keep people safe, but in the meantime they remained at risk of harm.

At our last inspection, Personal emergency evacuation plans (PEEPs) had not been updated to reflect changes in some people's mobility. This meant they may not receive the appropriate level of support if they needed to leave the premises urgently. PEEPs had been updated immediately after our last inspection, but had not been reviewed since. At this inspection, some PEEPs contained the wrong information about people's mobility and others did not reflect the fact that people had changed rooms and now had bedrooms on a different floor of the service. We raised this with the management team who updated PEEPs and introduced a system for prioritising emergency evacuations between day one and two of our inspection; however one person's current need to use a walking frame had still not been updated.

At our last inspection there was no choking risk assessment in place for a person who had chosen to eat un-softened meals against the advice of speech and language therapists (SaLT). At this inspection, two people had their meals specially prepared due to swallowing difficulties. There were no choking risk assessments in place for either person, to specifically make staff aware of the increased risk of choking for these people and how this could be prevented and addressed.

The failure to mitigate known risks to people and protect them from avoidable harm is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, staff were found to have a poor understanding of safeguarding issues and how these should be escalated. Although staff had an understanding of what action they should take at this inspection we continued to have concerns in this area. Two people had recently been found to have developed significant pressure wounds and the management team carried out a review of every person's skin to ensure that nobody else had any. Although there were no further pressure wounds, body maps showed that several people had a number of bruises, marks or sore areas on their bodies. Many of these had not been reported or mapped by staff prior to the reviews of people's skin carried out by the management team. Following their review, the management team were unable to tell us how these bruises and marks had been investigated. One person we met during the inspection had a small, worn dressing to their leg. There was no body map in place about this, no mention in staff notes and the management team were unable to tell us when the wound had occurred and how it had been treated and monitored. Staff were due to receive safeguarding training refreshers in the coming weeks but there had been insufficient oversight and action to ensure staff knew their responsibilities in relation to keeping people safe.

The failure to protect people from abuse and improper treatment is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

At our last inspection medicines had not been managed safely. The situation had not improved at this inspection. On the second day of our inspection, the medicines round took until 10:10am to be completed. Medicines administration records (MAR) were consistently signed by staff to show that people had received medicines at 8:00am, but some people received doses significantly later than this. This meant that there may not be sufficient gaps between their doses of medicine and was specifically raised as an issue at our last inspection. Best practice guidelines state that the exact time of administration should be documented if it falls more than an hour either side of that printed on the MAR. For example, one person received strong pain relief at 10:05am, but was due another dose of it at 12:00pm. There was no record made on the MAR to show the time this person actually had their first dose, so there was a risk that they would have their

lunchtime dose too soon. We brought this to the immediate attention of the provider who ensured this person had their second dose later in the day.

Other people had not always received their medicines as prescribed to them. One person had strong pain relief about which there are special legal requirements, and the MAR showed this should be given once every 12 hours. Our checks highlighted that there were several occasions when there had only been a gap of around 9 hours between doses. We made the provider immediately aware of this and they undertook to ensure medicines would be given at the correct times in future.

Another person had been prescribed antibiotics in early March 2018. The directions for their use included that the course of tablets should be completed. A reconciliation check showed that one tablet remained in the original box and two further tablets were unaccounted for. From 14 tablets, only 11 had been signed as administered by staff. The GP had been contacted for this person later in March when they continued to suffer with the original condition for which the antibiotics had been prescribed. Other people had not received their prescribed medicines due to a lack of stock; this should have been avoided by staff ensuring further supplies were available for people. One person had missed three doses of their calcium tablet and another person's pain relief had run out on 16 March 2018. This person had been prescribed pain relief for up to four times a day and their care plan documented that they were at risk of pain from a medical condition. In addition, they had several recent falls in which they experienced bruising, which might have caused them discomfort. Further supplies of the pain relief only became available on 22 March 2018, so there had been several days when this person had not been offered it in line with prescriber's directions.

A further person had current skin wounds which would be likely to cause them pain or discomfort. This person had prescribed pain relief for up to four times daily. The MAR showed that it had only been offered once each day and staff were unable to explain why this happened. On each occasion the person had been offered pain relief since 12 March 2018, the MAR recorded that they had declined it. However, their care plan documented that this person lived with dementia and also had a condition which meant they often said "No" even if they did not necessarily mean this. There was no information about how this person might express pain in a non-verbal way and no pain scales or charts were in use for anyone in the service. Pain relief had sometimes been prescribed for people in cream or gel form. One person had a condition which required application of pain relieving gel three times daily. Creams charts showed this had only happened three times in the ten days leading to our inspection. On most days the gel had been applied twice but one day there was no record of any applications at all.

Medicines belonging to a person who had moved from the service had not been returned to the pharmacy and were in the medicines trolley. This posed a risk that they could be administered to the wrong person by mistake. In several cases, there was more than one box of the same medicine open and in use for the same person, this made it harder to reconcile the number of tablets and was made more confused because staff had sometimes recorded incorrect numbers of tablets as being in stock or carried over from one month to the next. These issues combined to make effective auditing of medicines almost impossible and we asked the provider to carry out an immediate reconciliation of all medicines held by them and provide us a report of their findings. The provider did so, and sent this to us the day after the inspection.

The failure to manage medicines safely is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Temperature records of the medicines fridge and storage had been regularly recorded and were within safe limits. Liquid medicines and creams had been dated when first opened so that staff would recognise when they needed to be disposed of. Prescribed creams were stored in locked cabinets in people's bedrooms to

avoid the possibility of them being swallowed or applied too frequently by people living with dementia. Any known allergies had been highlighted on the MAR.

At our last inspection the deployment of staff had not been managed so that people's needs were consistently met. At this inspection we continued to have concerns about staffing levels and deployment. The provider told us there were six care staff including a senior in the mornings, five in the afternoons and "Three or four overnight". Two staff started their shifts at 12:00pm instead of 2:00pm on the afternoon shifts to provide extra support with the lunchtime service. The provider had not used a dependency tool or any formal calculation to show how they had assessed the number of staff needed on each shift, based on people's care needs. They were not able to describe to us how they had reached their conclusions that the numbers of staff deployed were adequate. Rotas showed that there were occasions in the last month where staffing levels fell below those the provider had told us about. These shifts were mostly, but not always covered by agency staff. There were several dates when only one care staff started their shift at 12:00pm rather than 2:00pm to give extra support across lunchtime

Records of falls showed that the vast majority of these had happened during the night shift. This was specifically raised by us at our last inspection but no auditing or trend analysis had been carried out before this inspection to inform the provider about staffing levels and efficiency overnight. The management team compiled falls information and trend charts by the second day of our inspection and the provider stated that there would be four staff on duty overnight going forward. They also undertook to carry out proper dependency scoring to work out staff levels going forward and we will check this at future inspections.

At the time of this inspection, there were some night shifts when there was no staff on duty that were deemed competent to administer medicines. This was a situation which had recently arisen. The provider said this was not a problem because a manager would give people's night time medicines before going off shift. However, this did not take account of people who had been prescribed medicines for use on an as required basis. This was generally pain relief, but could also be medicine given to ease anxiety or agitation. The provider told us that if a person needed PRN medicines in the night, then staff would call for on-call support to come to the service and give those medicines. This was an unsatisfactory situation which could lead to people having to wait for pain relief. The provider gave assurances that trained and competent staff would be rostered on all future night shifts. We will be checking that this happens.

The management team told us that three people were receiving "One to one care" for differing reasons. One person's care file contained two notes about minor confrontations with other people. This person had also had a recent injury. However, on arrival at the inspection, this person was observed pulling another person's arms and leaning over them in the main lounge. There were no staff in the vicinity to address this and the person was not receiving one to one support. Another person walked around the service unmonitored through much of the days of our inspection. At one point they sat with an inspector in a room for at least 15 minutes, without any staff intervention. At lunchtime they asked staff for food while they were supporting another person with their meal. Staff kept saying "Sit down [person's name]", but was unable to engage them further because they were helping another person. The third person needed support with a walking aid but they got up from their chair and walked without the aid on several occasions.

During lunch a member of the provider's family assisted with serving meals, even though they were not on the staffing rota. They told us that they came in a couple of times a week "To help out". It should not have been necessary for this to happen if there were enough staff deployed. On another occasion, a person asked activities staff to help them get up from their armchair. The staff told this person they were unable to assist because they were not trained to move people safely. The activities staff made attempts to find trained staff to help, but when they could not they supported the person to move from the chair themselves and despite

knowing they were not trained to do so. We received varied opinions from people about staffing levels; "Not enough staff their workload is too much" and "Definitely enough staff, all very friendly".

The failure to ensure enough staff were deployed to meet people's needs was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection there was a very bad odour in parts of the service and some areas and equipment had been unclean. At this inspection flooring had been replaced throughout communal areas and corridors and the odour had been eliminated. We had no concerns about the cleanliness of the service and staff appropriately used aprons and gloves when delivering personal care.

Recruitment processes continued to be robust, with all the necessary checks and documentation having been sought for new employees, including criminal records checks, references and identity information. Interviews were carried out using competency based questions and health questionnaires had been completed.

Safety checks on the premises and servicing of equipment had been completed by appropriate contractors within the required timeframes. The fire alarm had been tested weekly and other fire safety equipment such as extinguishers and emergency lighting correctly maintained. At our last inspection the provider told us they were arranging for a full safety review to happen, this took place in November 2017. The fire risk assessment was updated, at the same time, fire training was delivered to staff and a fire drill was completed. There were some safety actions arising from the fire risk assessment, the providers representative told us that no action plan had been put into place to address these actions. They agreed to send us this after the inspection.

Inadequate

Is the service effective?

Our findings

We received mixed feedback from people about the food at Lyndhurst, comments included; "The portions are good, you don't get a heaped up dinner, which puts me right off. You occasionally get a choice", "The variety is not there with the food", "Sometimes you sit here for three quarters of an hour waiting for lunch it is a bit haphazard." Relatives told us their loved one, "Eats really well, uses a plate guard but doesn't need assisting" and "Food is fine, mum has put on weight since she's been here."

At our last inspection we reported that people were not adequately protected from the risks of poor nutrition and hydration. On the first day of our inspection, we observed the lunch period in the main lounge; the meal did not look appetising. It was meat loaf, served in very thin slices; which looked grey. One person was heard complaining to staff that their meal was cold. Although the plate was warm underneath the food itself appeared to be lukewarm. This person was offered another meal but refused it. They ate very little of their lunch.

For the evening meal we observed trolleys of sandwiches taken around both lounges where most people were sitting. We were told the choice was jam, cheese and pickle, cheese and spring onion, tuna and cucumber, ham, ham and tomato or corned beef. However, when we saw the trolley there was only jam and tuna and cucumber left. We asked if other sandwiches were made if a person wanted a different choice and were told if only half the tin of corned beef had been used then they would be able to make some but they would not open a new tin. Bought cakes and crisps were also available. We asked if the cook made cakes and were told they did for people's birthdays.

The management team told us two people had their food specially prepared for them. One person was having pureed foods because staff had noticed swallowing difficulties with medicines and told us the family had asked for meals to be pureed. However, specialist advice from SaLT (Speech and Language Therapist) had not been sought at the time of our inspection.

Staff had received revised advice from SaLT by telephone about another person's diet. Records about this were almost unreadable because the handwriting was poor but they said that the person had been visited by SaLT when the management team assured us this had not happened and the advice was given by phone only. This person' care file contained the previous advice sheet from SaLT, which had not been updated and could create confusion over the correct consistency of the person's meals. Although the cook had been told verbally of the updated advice, the documentation held in the kitchen related to the previous instructions.

We spoke with the chef who told us that staff went around in the morning to collect menu choices. The chef only worked three days and a member of care staff cooked the other days. We were told that they were recruiting another chef and a kitchen assistant. They also said the menus were three years old but it was hoped they would be reviewed in the near future.

We looked at the menus on the notice board and there were four menus but none of the first days menus showed the food that was on offer. We asked a member of staff which week it was, they checked the lunch

that had been served but was unable to tell us.

At the last inspection we had concerns around people being referred to appropriate health professionals in a timely manner when weight loss was identified. At the inspection our concerns remained. One person had lost over 5kg's over the previous six months and had not been referred for further support, despite being told that this would take place if people lost 3Kg or more. We were told a referral would be completed following the inspection.

We raised concerns about the recording of food and fluid charts at our last inspection. At this inspection our concerns remained. Food and fluid charts were completed for people who had been assessed as requiring monitoring, however, we found that they were not completed accurately, therefore providing ineffective monitoring because they contained insufficient information for the registered provider to determine whether people at known risk from poor intake were receiving adequate nutrition and hydration. For example more than one person had two recording charts for each day – one for food and fluids and one for fluids. The fluids on both charts did not match, meaning that it was not possible to gain a clear picture of actual fluid intake.

The failure to mitigate risks to people in relation to hydration and nutrition is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found a lack of understanding around the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service.

At this inspection we found that there was still a lack of proper understanding of the requirements of the MCA, for example there was no DoLS application or authorisation for a person who frequently asked to leave the service to go home. We observed this happening on several occasions during the inspection. Consent forms in care files had not been signed for people in relation to the use of photos, even though photos were in use in the MAR folder, bedroom doors and on the care plan. On another 'Permission for use of photo ID' form it had been noted that the person was assessed on 1 March 2017 as not having capacity to make this decision. However, there was no associated MCA assessment document on file to show this had been carried out. The management team confirmed that no MCA assessments (or DoLS considerations) had been carried out for people in relation to the use of alarm mats in their bedrooms.

MCA assessments had been made for other specific decisions but associated best interest decisions had not always been made in consultation with professionals or documented the least-restrictive practice considered. Staff daily notes recorded when people's verbal consent had been given for particular care tasks.

The failure to operate within the principles of the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us they had spent time the day before our inspection identifying who had or had not had received DoLS authorisations, as records at the service were not clear. They told us they continued to liaise with the relevant authority to establish the exact position of all applications and authorisations. The registered provider had not notified the CQC when authorisations were received. Since the inspection we have received one notification. This is a legal requirement.

The failure to notify the CQC of the outcome of DoLS applications is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection we reported that risks to people's health had not been appropriately assessed and minimised. At this inspection we found that there had been some improvements but some areas remained a concern. At our last inspection we found that there was a lack of understanding about the importance of monitoring weight loss and the importance of screening for the risk of malnutrition; enabling early and effective interventions to be introduced. Established care sector monitoring tools, such as the Malnutrition Universal Screening Tool (MUST) continued not to be used and because of a continued lack of information, staff remained unable to correlate people's weight to BMI scores to identify if people were at risk. At the last inspection we reported that where weight loss was evident, people continued to be weighed at the same intervals as people who had not lost weight. This remained the case at this inspection. One person, who had been identified as at risk of weight loss, had it recorded on their weight monitoring chart in October 2017 that they should be weighed every two weeks. The chart documented that they had been weighed on 12/10/17,31/10/17, 07/11/17, 07/12/17, 31/12/17, 14/01/18 and 16/02/18. During this period their weight had fluctuated but in total they had lost over 5kg.

Some people had skin wounds or pressure areas. The district nurse visited regularly to assess and dress people's wounds. People's dressings appeared clean and some people had special inflatable boots on to help protect their skin. Visits from the podiatrist and chiropodist happened regularly and there was evidence that people had seen opticians. The GP responded to requests from the service to visit people when there were concerns about their health. However, one person during the inspection had been complaining of knee pain. They had been supported by staff from the home to attend an x-ray, the results of which had not been received during the x-ray. During the GP visit on the second day of our inspection, the deputy manager requested increased pain relief for this person, however, the GP felt that he prescribed paracetamol was sufficient. Following the inspection we received a notification to advise us that the home had taken this person to A&E due to their increased pain and it was identified that they had a fracture to the knee.

At our last inspection special air mattresses for people at risk of skin breakdowns were on the wrong settings. At this inspection all but one mattress was set at the right level to ensure the person received the correct therapeutic benefit of it.

Where people had conditions such as diabetes, health care plans provided guidance about high and low blood sugar level (BSL) readings and what to do in these circumstances. However, they did not contain clear or accurate guidance. For example, one person's diabetic care plan gave guidance to staff round testing their blood sugar levels twice daily. We were told this was inaccurate as district nurses visited this person to test their blood sugars and this was not done by staff at the service. This is an area we have identified as requiring improvement.

Diabetes can place people at greater risk of other health concerns such as circulation and eye problems. Care plans had been improved to include guidance within diabetic care plans for staff to monitor and observe.

At our last inspection we reported concerns about the effectiveness of training that staff received. At this inspection we still had some concerns, for example the understanding of putting into practice moving and handling techniques the day after receiving training. During the week preceding this inspection, the registered provider had told us that they were changing their training provider. They had booked medicines training that took place the week before our inspection, moving and handling training that took place the week of our inspection and other essential training which included; Basic Fire Safety, Basic First Aid, Equality and Diversity, Pressure Area Care, Dementia Awareness, Safeguarding Vulnerable Adults, Mental Capacity Act and Deprivation of Liberty, Basic Health and Safety, Infection Control and Food Hygiene Awareness. These training sessions included a knowledge check to be completed; these should help to identify any gaps in knowledge or understanding. As this training had not taken place at the time of the inspection we were not able to make a judgement on its effectiveness. We will follow this up at our next inspection.

There were some agency staff working during our inspection, we spoke with three of them who all said they had not read people's care plans before starting work with them. We asked one agency staff about a person they were supporting to drink abut they were unable to tell us the person's name or any of their care needs. Another agency staff was looking after a person living with dementia who could not verbally express their needs. This person's care plan described the specific way in which the person would indicate they needed to use the toilet, but this information had not been passed to the staff member. However, they did tell us that they had offered this person the toilet regularly throughout the day. The induction of agency staff is an area that requires improvement. We recommend the provider introduces a process of inducting agency staff to the service.

The provider's area manager told us about presentations that they planned to give to the staff team, to enhance their knowledge and understanding. They told us they had given these at another of the provider's services and that staff feedback was positive. The presentations covered topics such as falls, mobilising and pressure area management. They told us they hoped these sessions would complement the training and open up discussion.

The provider's area manager and the new deputy manager had taken over supervision and appraisal sessions with all members of staff, since the home manager had left. New staff received an induction, we reviewed the provider's paperwork and they told us they planned to review and update this in the near future.

There was limited information about people's preferences. For example, about people's religious or spiritual needs and how these might be met, or records of whether people preferred male or female care staff to support them with personal care. The management team told us that care plans were in the process of being re-written and updated to be person centred and include a clear picture of people's choices.

There was some improvement to the adaptation of the premises since our last inspection. The service had been redecorated in communal areas; which gave it a bright and fresh appearance. The management team told us that they had researched the colours scheme to ensure it was appropriate for people living with dementia. They also told us that they had plans to decorate with hanging pictures and to further improve the environment for people living with dementia they intended to purchase picture signage. This could help people identify communal rooms or toilet facilities or help people to orientate themselves around the service.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people's dignity had not always been protected. At this inspection there had been some improvements but there were still occasions when people did not receive the respect they deserved.

One person had complained to us about loud noises made by staff outside their bedroom door. They said this "Makes my life a misery". On the second day of our inspection we heard two domestic staff shouting extremely loudly to each other, even though they were working together. This was right outside the door of the person who had spoken with us and inspectors heard the sound clearly even though they were in another room with the door shut some distance away. There was no consideration shown for the fact that the service was people's home and that some people liked to remain in their rooms or have a rest in the afternoon.

We observed a person being supported with a hoist in the main lounge, where other people, staff and visitors sat. Staff rummaged between the person's legs for the hoist sling with no conversation or reassurance offered. As they hoisted the person into the air their bare thighs were completely exposed. When staff realised they were being observed, they attempted to pull down the front of the person's skirt but this had no impact on the back of the skirt which was gaping open and showing the person's underwear. This was not respectful of the person's right to dignity.

Although people appeared generally better presented than at our last inspection, several female service users had facial hair growth. We asked the managers about this and whether it was people's choice to present themselves in this way. They said that this would be an area they would address sensitively going forward.

During the morning on our second day at the home, a member of staff came into the lounge and said they were going to do a quiz. They asked people to move chairs and one lady was moved from one chair to another. A lady entered the lounge with her zimmer frame and the member of staff tried to direct her to a chair but the person said she didn't want to sit in that chair and moved to another. The member of staff said "I was going to sit there but never mind" in an irritated tone. They then went to the dining room and brought a chair to sit in so that they could start the quiz.

A little while later, staff came into the lounge to give people hot drinks, biscuits and fruit. People who were dozing were woken up to be given a drink. One lady kept trying to attract the attention of staff to get her a drink but staff did not acknowledge her for approximately five minutes even though other people had been given their drinks and offered biscuits and fruit. When she was eventually given a drink she was extremely grateful.

Records of baths and showers showed that some people continued to have long gaps between them. One person's care notes commented that there was a "Build- up of dirt" under their stomach when staff had supported them to bathe. It had been two weeks since their last bath when this record was made. Bathing records showed this person generally had weekly baths however. Another person's care plan said they

would like weekly showers but bathing records showed there had been five weeks between showers. This situation had been undignified for people and the management team said that bathing and showering would be more frequent going forward.

The failure to protect people's dignity and treat them with respect is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was limited evidence within care plans to show that people were involved with decisions about their care. People we spoke with said they had not been involved with their care planning. However, the deputy manager told us that they had begun to involve people and relatives in care planning. They said they had discussed two people's care with their relatives the day before the inspection. People we spoke with told us they did not get much of a choice in meals and that they were not involved with menus.

Staff spoke kindly with people and one agency staff was observed with a person pressing their face into theirs in an affectionate gesture. The agency staff was gentle and allowed the person to feel the staff's face and the person clearly felt at ease with them. Staff were heard using affectionate terms when speaking with people such as "Let me help you darling" and "Would you like a different meal, love?" People seemed to like these terms of endearment and people appeared relaxed and comfortable with staff. We observed some kind and considerate interactions that respected people's privacy; a member of staff was observed discreetly telling someone that when they had finished their drink, they would take them to the toilet. The member of staff got down to the person's level and spoke into their ear.

We received some positive feedback from people and relatives about the caring nature of staff at Lyndhurst. Comments from people included; "Carers look after us well", "All the carers are good", "I have been very well looked after" and "Different ones care more than others." Visiting relatives told us, "We are very happy, every member of staff will talk to you, if we've got any concerns we just talk to a member of staff and it is resolved before we leave" and "I am very happy with all the staff, they are very approachable, even the cleaners and laundry staff, they are all very friendly."

People were encouraged to be as independent as they could and one person was observed laying up lunch tables, because this was something they enjoyed. Some care plans recorded the tasks that people could manage for themselves and those that they would require support to complete. One member of staff told us, "She loves her bath, sometimes you can have a conversation, she's physically calm when she gets in the bath, I encourage her to wash herself and sometimes she will." One person told us, "No one interferes they allow you to get on with what you want to do", I lay the tables every day and fold the serviettes it keeps me busy" and "I am quite independent I have a shower every morning, there are always plenty of towels."

Some people required additional support to communicate; there was minimal support around the home. There were some picture menus on display, although they displayed pictures of different meals to the days menu, this could lead to additional confusion for people. The area manager told us they planned to improve signage around the home to assist people.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we raised concerns that people's care plans were not being followed in practice. At this inspection care plans were in the process of being re-written. However, this work had been carried out by a consultant, rather than staff and managers with knowledge of people's care needs and personalities. As a result the newer care plans were not always person-centred and often contained mis-matched, incomplete or out of date information. For example; one care plan stated in two separate documents that the person's religion was Church of England and Roman Catholic. A person was described as 'happy and outgoing' when other documents suggested this was not the case. Another care plan recorded that a person was at risk of falling because they could be unsteady on their feet and stated 'Should [person's name] have an alarm mat to alert staff when they get out of bed at night?' The same care plan recorded a person's medical condition and asked whether they should have pain relief in place for it. Another person's care plan queried how often a person's continence pad should be changed and a further plan said that the person needed creams applied to pressure areas when no creams were prescribed for them. All of these anomalies placed people at risk of receiving inappropriate care and treatment.

The management team told us that they would be addressing all the questions arising in people's care plans and also working to make these more personalised. In the meantime, however, the care plans made it clear that not all risk to people had been properly considered at the time of our inspection. The impact from the lack of adequate care planning was increased because a number of agency staff were being employed by the provider. Our discussions with these staff found that they had minimal knowledge about people's care needs and the current mix of old and new care plans were not helpful in providing them or existing staff, with clear information or directions. The format of the newer care plans provided an improved template for staff and managers to document risks and actions to reduce these, once they were populated with updated, accurate and person-centred details.

Information about people's wishes and preferences for end of life care varied in detail between the plans we reviewed. Some were blank with a note that management were to discuss end of life with relatives. The provider told us about one person who had thought to be reaching their final days but had rallied. This person's care plan about end of life recorded that their next of kin should be informed if they passed away, the name of the funeral director and that a do not resuscitate order (DNAR) was in place. The plan made no mention of how the person could be made comfortable; including how any pain or anxiety might be managed. There was no reference to any particular preferences the person might have, but this may have been difficult to determine as they lived with dementia.

The failure to provide person-centred care, designed to meet people's needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection there was not a robust system in place for responding to complaints. We still had concerns at this inspection. Following our last inspection a complaints spreadsheet had been put into place, however, this was only partially completed. Two complaints from relatives were recorded and responded to. Although investigations had taken place, the responses did not address the main components of the

complaints. We asked the area manager whether there had been any recent complaints other than the two recorded on the log and we were told not as far as they knew, and none in the three weeks since they started working at the service. One person's relative told us, "A month or so ago I came to pick her up and she had a handful of pills which she called her' crumbs'. I saw a little yellow one and a little red one. I told the staff and she is now on pill watch." We asked the management about this, they were aware of the incident but it had not been logged as a complaint or investigated.

The complaints procedure displayed on the notice board did not clearly set out timescales and roles and responsibilities. Although it referenced an 'ombudsman' it did not give any details of which one or contact details. The policy stated "All complaints, however trivial, are to be investigated. All complaints will be acknowledged within 24 hours and a response within 28 days'. The complaints that we reviewed had not been responded to in line with this policy.

The lack of a robust complaints system is a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We received mixed feedback from relatives about raising concerns. One relative told us; My sister picks my mother up, a couple of times she complained that she was very smelly so she is now having more regular baths." Others commented "I'm happy to tell someone if I don't like something", "I couldn't complain about this place at all", "We never interfere with the way they look after mum but if we had to we would speak up for her and would have no problem in making a complaint" and "I like the new flooring, the old carpet smelt but you could put up with the smell because the staff are so good, I did complain about a resident walking around with his shirt off".

People were engaged in a variety of activities during the two days of our inspection. These included quizzes and puzzles, crafts, sing- a-longs, going out for a walk and a chocolate tasting session. There was a display board, however this displayed different activities to the ones observed. Not everyone was able to take part however, and some people sat in armchairs and slept for large parts of the day. The service employed two activities staff who worked between Mondays and Fridays each week. Some people preferred to stay in their bedrooms and daily staff notes recorded when staff had visited them to offer a chat or some other activity.

One person told us, "I went out with the activity leader this morning for a walk. When we said we'd had enough we came back. It was quite cold and it would have been nice if we'd had a warm drink when we got back." Other comments included; "It's really lovely here, I join in with the activities there is a very friendly atmosphere", "I like to do jigsaw puzzles, I am very good at them", "I go to Age Concern at Herne Bay once a week. I like to play cards and dominoes but a lot of people have breakfast go in the lounge and fall asleep", "We watch a film occasionally but you can't really get into it with all the people moving around" and "I go into the garden in the summer." Relatives told us, "It would be nice if the carers could take her out for a walk" and "I encourage her to join in with activities, she still plays cards."

Inadequate

Is the service well-led?

Our findings

At our last inspection the service had not been well led. At this inspection, we found that there had been some improvements such as the environment but there were many areas that had not improved sufficiently.

There was no registered manager; there had been no registered manager since December 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. It is a requirement of the provider's registration that there is a registered manager in post. Following the last inspection we cancelled the registered manager's registration with the commission.

The registered provider told us that they had faced with a number of challenges since the last inspection that had resulted in delayed improvements. They had not at the time of our inspection been able to recruit a suitable manager for the service, having had two different managers in post since the last inspection. The registered provider had also appointed a consultant following the last inspection; however, just prior to this inspection they had ended their working relationship with them. At the time of this inspection, a deputy manager had been in post for three weeks and the providers' area manager had been moved to work full time at Lyndhurst to work with the deputy manager in implementing improvement actions.

The provider's consultant had submitted an action plan and progress reports; these demonstrated that some actions had been taken in relation to improving medicines management, identifying training needs and beginning improvements with care planning. However, as we have reported, improvements had not been sufficient or embedded into the service. The provider's area manager and deputy manager were positive and keen to tell us about improvements they planned to introduce in the coming weeks.

Following our last inspection, a number of audits had been introduced, however none of these had been completed since December 2017 and at the time of our inspection there were no audits being completed at the service, resulting in the registered provider failing to have identified the on-going shortfalls and or have an accurate oversight of the service. For example; no auditing of medicines was in place meaning that the management had no oversight of medicines. Due to our concerns with the management of medicines we asked for a complete reconciliation of medicines to be completed. This was sent to us the day after the inspection and identified some shortfalls. The provider had also arranged for an external company to complete a medicines audit, however, this had not been received at the time of our inspection.

Risks to people had not been adequately assessed, monitored and minimised. This was as a result of the lack of auditing, action planning and insufficient management oversight. Some risks that were highlighted in our last inspection report were still not mitigated at the time of this inspection. This included; falls audits, monitoring of food and fluid charts, monitoring of weight losses, review of bathing and showering records, staff training and operation of the MCA. The provider's area manager showed us a falls analysis that they completed during the inspection and told us they planned to introduce these into the service going forward.

At the last inspection we identified that a number of falls took place over night. This information could have been used by the registered provider to assess the levels and effectiveness of night staff, and consider measures such as specialist alarm equipment to help prevent further falls. However, falls continued to occur over night and no assessment had taken place. The registered provider told us there were either three or four members of staff overnight. When we queried how this level was assessed, the registered provider told us they would increase the number to four each night.

Feedback had been sought from relatives by way of a questionnaire; these were sent out to relatives in March 2018, and previously in November 2017. Questions included the appearance of the home, questions about the environment, complaints procedure, cleanliness, meals, independence, activities and communication. The questionnaire also allowed for any additional comments. There was some negative feedback in the quality assurance questionnaires regarding attentiveness and responsiveness to concerns and the procedure for making complaints and receiving feedback. Some people had raised concerns as part of the feedback and free text for the questionnaires, however these had not been acknowledged or responded to and had not been picked up by the provider. This included people raising that they were not aware of the complaints process and had raised concerns that had not been improved or followed up.

When speaking with the provider's area manager they said that when questionnaires were sent back they reviewed the answers to the individual questions and looked at how to action plan. We asked what they had done with the responses received in February and March and they said that they had not had a chance to review the responses yet. A letter was sent to relatives in December 2017 following the feedback questionnaires sent out in November 2017 which acknowledged all the comments raised such as laundry, garden area, activities, cleanliness of rear dining room, welcome, staffing levels, smell in lounge area, compliments and complaints procedure, dirty nails/hair, staff board and disabled parking. The response to feedback is an area that requires improvement.

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

There was a file of compliments and thank you cards which included comments such as "Please accept my gift as an expression of my love and respect for you and the work that you do", "Thank you for all your help and support with mum" and "Thank you for all you do for my mum".

The vision and values of the organisation were recorded as "To improve and maintain the lifestyles of residents by providing a patient centred approach which embraces aging with energy, compassion and respect". Links with the community had been fostered through visits from church ministers and a local choir which regularly came to sing for people.

There was friendly atmosphere and cooperative culture amongst staff and managers during the inspection. Staff told us they were feeling positive and could see some changes were creating improvements for people. One member of staff said, "I feel supported if I speak to seniors, and [the deputy manager] seems down to earth, you can tell them if there is a problem. The owners come round and have an involvement now. The last inspection got me really down, staff morale was low." We also received some positive feedback from people and relatives, comments included; "Owner is very approachable, have reassured us they won't move her on",
"I know who the owner is, there is a new manager", "The improvements have gone above and beyond what needed doing. No disruption to residents while it was being done, the contractor was really great with the

residents" and "I have recommended the home to other people."

The providers' area manager and deputy manager told us that they were kept abreast of developments in social care through joint working with the management teams of the provider's sister services and input from the Clinical Commissioning Group, local authority and a range of visiting health professionals. It was felt that these working relationships could be improved for the benefit of people using the service, and at times the registered provider felt they received little in the way of support.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The deputy manager was aware that they had to inform CQC of significant events in a timely way and notifications had been received appropriately since they commenced their role, they had completed and submitted retrospective notifications for events that had not been reported appropriately by the previous manager. They had not however, submitted notifications to tell us about the outcome of DoLS applications.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception area and on their website.