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Lyndhurst Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Lyndhurst Residential Home, known as Lyndhurst, took place on 28 and 29 November 2017 and was unannounced. In July 2016 the home was rated as Inadequate and placed into special measures. We inspected the home in January 2017 and again in July 2017. The most recent inspection of July 2017 found the home required improvement but had made sufficient improvements to be removed from special measures. There were no breaches of regulations at the last inspection.

Prior to this inspection we had received some information of concern regarding staffing levels, food provision and staff training. We did not find evidence to corroborate these allegations. However, during this inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulation 17, good governance.

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

Lyndhurst is registered to provide care for up to a maximum of 15 people, some of whom are living with dementia. Accommodation 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. There were ten people living at the home on a permanent basis at the time of our inspection and one person staying at the home on a temporary, respite basis.

The home had a manager in post, who had recently been appointed. They had not yet registered with the Care Quality Commission, although they had begun the process of their application. 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.

The registered provider had a safeguarding policy in place and the staff we spoke with understood the signs to look for which may indicate potential abuse. Staff were clear about who they would report safeguarding concerns to.

We observed sufficient numbers of staff to keep people safe and everyone we asked told us there were enough staff to keep people safe. However, we recommended the manager consider using a tool or system to ensure staffing numbers are sufficient. Staff were recruited safely.

Risks had been assessed, such as those relating to medication, skin integrity or falls. Measures had been introduced to reduce risk. However, the risk assessments had not been updated regularly. We saw moving and handling plans were in place which provided staff with information in order to safely assist people to move.

Regular safety checks took place and fire, gas and electrical systems had been tested. Plans and evacuation equipment were in place to safely evacuate people in the case of emergencies. Staff had been trained how to use evacuation equipment effectively.

Medicines were managed, stored and administered effectively and in a safe way. Staff that administered medicines had received specific training to do so safely.

Staff received regular training and observations of their practice. Staff told us they felt supported. However, regular formal supervision for staff was lacking.

The home was in need of cosmetic improvements such as redecorating and carpeting in some areas. There was only one bathroom in use which people used to bathe. There was no facility to shower. This was also found at our last inspection.

Decision specific mental capacity assessments had been completed for people who lacked capacity to make specific decisions, and decisions were made in people's best interests, as required by the Mental Capacity Act 2005.

People were supported to have maximum choice and control of their lives and staff supported people in the least restrictive way possible; but only in so far as the amenities of the building would allow. For example, people did not have the choice to have a shower because these facilities were lacking.

People received appropriate support in order to have their nutrition and hydration needs met. Mealtimes were a pleasant experience and people enjoyed the food.

All of our observations indicated staff treated people with kindness and compassion. People told us staff were caring and we observed people's privacy and dignity being respected. People were encouraged to maintain their independence. Visitors were welcomed and there was a pleasant atmosphere in the home.

Care plans contained person centred information, including people's personal histories, likes and dislikes. Staff were aware of people's needs and preferences and care was provided in line with care plans. Although staff clearly knew people well, care records showed limited information had been gathered in relation to people's cultural, religious or sexuality needs. End of life wishes were not consistently recorded.

Some people told us, and records showed, activities were not meaningful for some people living at the home. This was also found at the last inspection.

Up to date records of the care and support offered and provided were not always kept.

Since the last inspection, efforts had been made to gather people's views in relation to their meal-time

experience. However, regular meetings with residents and relatives had not taken place.

Audits and quality assurance systems had continued to develop and improve some areas of the service since the previous inspections. However, these were not consistently effective and some areas which had been identified for improvement had not been actioned.

We made some recommendations in relation to how staffing numbers are determined and also in relation to the environment. You can see what action we told the provider to take at the back of the full version of the report. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe.

Risks to people had been assessed but had not always been updated. Actions taken to reduce risks had not always been recorded.

Safe recruitment practices had been followed.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction and ongoing training. However, formal staff supervision was inconsistent.

The principles of the Mental Capacity Act 2005 were followed.

Information was not always made available to people in accessible formats.

People received appropriate support to have their nutrition and hydration needs met and people liked the food.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity was respected and personal information was kept confidential.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us, and we observed, a lack of activities or meaningful occupation.

Care plans included information relating to people's likes and dislikes as well as their care needs. However, some information, in relation to cultural, religious or sexuality needs was not evident.

People were encouraged and enabled to maintain contact with those important to them.

People and their relatives felt able to complain if the need arose. There was an effective system in place for handling complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a new manager in post, who needed time to develop the service further. People and staff told us they had confidence in the new manager.

Regular residents' and relatives' meetings had not been held.

Audits were in place and these had resulted in some improvements to the quality and safety of the care and support provided. However, not all audits were effective and some areas identified for improvement had not been actioned.

Relevant policies and procedures were 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 was 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.

The inspection took place on 28 and 29 November 2017 and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience on the first day and an adult social care inspector on the second 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.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority contracts, commissioning and safeguarding teams as well as information we received through statutory notifications.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with six people who lived at the home and five visitors to the home. We also spoke with seven care and support staff, the cook and domestic staff and the manager.

We looked at four people's care records, five staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Our findings

All of the people we spoke with, with the exception of one person, told us they felt safe living at Lyndhurst. Comments included, "Do I feel safe? Of course I do," and, "Yes, I do feel safe living here," and, "Yes, I feel absolutely safe here." One person told us they did not feel safe because they heard noises throughout the night. Visitors told us, "Yes, I feel [my relative] is safe here," and, "I believe there are enough staff."

The manager and all the staff we spoke with were able to outline the actions they would take if they had any safeguarding concerns and the registered provider had an up to date safeguarding policy. Staff were able to identify signs which may indicate a person was at risk of abuse or harm.
This helped protect people from abuse because staff were aware of appropriate action to take if they had concerns anyone was at risk of abuse or harm.

The manager was aware that, previous to this inspection, we had received some information of concern from an anonymous source. They had therefore introduced a system to enable and encourage staff to share their views, comments or concerns. The staff we spoke with were aware of this system and told us they could share any concerns they had. We specifically asked all of the staff we spoke with whether they had any concerns about the safety of people living at the home or whether they wished to share any other issues with us. All of the staff we asked told us they had no concerns and they were aware how to raise any concerns they may have.

Individual risk assessments had been undertaken to enable people to retain independence and make their own choices, whilst minimising risk. Some risk assessment tools were used to identify common risks such as those relating to falls, skin integrity and medication. Additional assessments of specific risks took place when this was relevant. Although staff were able to outline to us the risks specific to individuals living at the home and the measures in place to reduce risk, some of the risk assessments we reviewed had not been updated since May 2017.

One person's record indicated they were at high risk of skin damage. The person's record showed their skin was, 'Really sore' in October 2017. However, despite this, their risk assessment relating to this had not been updated since May 2017. Another person's record indicated the person was, 'Very high risk' in relation to their skin integrity. One of the risk reduction measures was that the person's skin would be checked daily. However, the last recorded skin check was in June 2017. We highlighted this to the senior carer and manager, who assured us the person's skin was checked daily and staff confirmed this. However, this meant

appropriate records had not been kept and the risk assessments had not been updated.

The above demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have effective systems in place to assess and monitor risks relating to health, safety and welfare of people and accurate, contemporaneous records were not always kept in relation to people's care and treatment.

One person had a pressure mat in place, which would alert staff to movement and reduce the risk of injury from falls. When it was identified the person had not sustained any falls and they were independent getting in and out of bed, the mat was removed. This showed the risk was assessed and the least restrictive options were considered to enable the person to retain their independence.

Care records indicated the assistance people required with their mobility. Where assistance was required, further plans were in place to guide staff how to safely assist people with equipment such as a bath hoist or chair lift. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely.

Records relating to care provision were securely stored. Records showed people were weighed regularly and information relating to care provision, such as nail and oral hygiene and bathing were completed and up to date and, where this had been refused, this was recorded. Records showed regular night-time checks were made, according to people's care needs. This helped to keep people safe.

We did not see any behaviour that may challenge others during our inspection. However, some people did require much attention and reassurance from staff. We observed staff used appropriate distraction techniques to help improve people's well-being and to support people safely and effectively.

Regular safety checks took place at the home, such as those in relation to gas and electrical safety. Records showed fire equipment had been serviced. Systems such as fire alarms, emergency lights and fire doors were tested regularly. Lifting equipment had recently been examined. This helped to ensure the safety of premises and equipment.

Staff we spoke with were able to outline the actions they would take in emergencies, such as in the event of a fire. Staff had been trained how to use evacuation equipment. Personal emergency evacuation plans had been developed for individuals living at the home. Information was included such as the equipment needed and how staff should assist each person to evacuate the building in an emergency. A member of staff told us they had been in the evacuation sledge during training, so they had experienced what it would be like for the person being evacuated. Emergency evacuation procedures were displayed. This showed plans were in place to evacuate the building in the event of an emergency.

Records showed accidents and incidents were recorded and reported. Appropriate actions were taken such as first aid being applied and referrals being made to other health care professionals. The manager was able to outline to us the actions they would take to ensure lessons were learnt from incidents. Accidents and incidents were analysed in a way which enabled trends to be identified.

Prior to our inspection we received information of concern alleging staffing numbers were insufficient to safely meet the needs of people living at the home. We found two care staff were deployed between 8am and 8pm with an additional carer being deployed between 10am and 6pm, as well as domestic and catering staff and the manager. Additionally, a team leader worked 8am to 4pm three days each week, supernumerary to care staff, which meant they were not counted in care staff numbers. Two care staff were

deployed between 8pm and 8am. There were ten people living at the home at the time of our inspection and one person residing at the home on a temporary respite basis. One person living at the home required the assistance of two staff to assist them with personal care.

All of the people and staff we spoke with told us they felt there were sufficient numbers of staff to keep people safe. One person told us, "As for the numbers of staff, if you want anything, they're there." Another said, "Yes, there seems to be enough staff." A visitor told us, "Yes, I believe there are enough staff." We observed people's needs being met in a timely manner by staff throughout our inspection. A member of staff told us, "I didn't think we had enough until we had the ten-six [10am to 6pm]. The manager is more hands on than the previous manager. We don't struggle." Staff took time to speak with people and continually asked whether people were okay throughout the inspection. However, it was clear from looking at staff rotas that, if two members of staff were assisting the person who required two staff to assist them, there would be no other carers available to meet people's needs between the hours of 8am and 10am and 6pm and 8am.

We discussed staffing levels with the manager. They told us they did not use a system in order to help determine the numbers of staff required. We queried how the manager could therefore accurately determine the numbers of staff required to meet people's needs, particularly when numbers of people or dependency changed. Using a dependency tool is one way which helps managers to calculate the level of dependency at a home and therefore assist in determining the number of staff required.

We recommend the registered provider implements a system for determining safe staffing levels.

We inspected five staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at how medicines were managed and administered and found these to be managed in a safe way. Medicines were managed and administered by staff that had received specific training to do so and their competency was regularly checked.

Medication Administration Records (MARs) contained a photograph of each person, which helped to reduce the risk of medicines being given to the wrong person. We observed the member of staff administer medicines in a calm and kindly manner. The medicines trolley was locked in between each administration and the trolley was secure and well organised.

Some people were prescribed, 'As required,' or PRN medicines. PRN protocols were in place for these types of medicines. PRN protocols help to ensure, 'As required' medicines are administered appropriately and at safe intervals.

If medicines were not given for any reason, this was recorded appropriately. The member of staff was able to explain to us the action they would take in the event of a medicines error or if the amount of medicine remaining did not reconcile with records. Whilst taking their medicine, one person dropped their tablet on the floor. The member of staff took appropriate action and recorded this. This showed staff knew the actions to take in the event of medicines being destroyed or not being administered.

We counted a random sample of medicines and the amount remaining reconciled with the MARs.

Body maps were used when creams were administered. This helped to ensure staff applied creams

appropriately, to the correct area of the body.

The member of staff was aware which tablets were time specific, for example those which must be given 30 minutes before food intake. We observed the staff member ensured the person took these medicines at the correct time.

We checked the controlled drugs, which are prescription medicines controlled under Misuse of Drugs legislation. Controlled drugs were stored safely and appropriate systems were in place to ensure these were managed effectively. One controlled drug was in stock during our inspection. We saw, where this had been administered, two members of staff had signed the register and the amount remaining reconciled with the register.

We observed staff using personal protective equipment appropriately in order to reduce risks associated with infection. The home appeared clean and smelled fresh.

Requires Improvement

Our findings

People felt staff had appropriate skills to perform their roles effectively. We were told, "They seem to have the right skills and they're not rushing about," and, "I've never seen anything that concerns me." In relation to the food, comments from people included, "I like the food. If there was something I didn't like they would do something else for me."

The registered provider made use of technology for some safety equipment, such as sensor mats. These can be effective at alerting staff to people's movements, which can help staff to keep people safe.

No staff working at Lyndhurst were new to the caring profession. Records showed staff received an induction into their role, which included shadowing more experienced members of staff. A member of staff told us they had shadowed more experienced staff for two weeks prior to commencing their role as a care assistant. They explained how they shadowed across all different shift patterns, so they were familiar with people's needs throughout the day and night. This showed staff received an appropriate induction into their roles.

All of the staff records we reviewed showed staff had received training in essential areas such as safeguarding, moving and handling, fire safety and administering medicines where appropriate. A student volunteer worked at the home on occasions, during a weekend. Training had also been provided to the volunteer in areas such as safeguarding, health and safety and dementia care. Staff told us they felt they received sufficient training. This showed staff and volunteers received training to enable them to perform their duties effectively.

We inspected five staff files and found staff did not have regular formal supervision. We could not find a policy which indicated how often staff should have supervision so we asked the manager, who was unclear about how regularly this support should be provided. Records showed one staff member last had formal supervision in February 2017, another in June 2017 and another in May 2016. A member of care staff told us, "I was meant to have supervision with [previous manager] but they left." This staff member told us they did not have regular one to one supervision, but they felt confident in their role and able to approach the new manager. Formal supervision is an important process for staff to reflect on their performance and discuss any concerns or training needs they may have. We shared our findings with the manager. Following the inspection, the manager forwarded us records of two further formal staff supervisions which had taken place in January 2018 and assured us staff supervision was taking place.

Regular staff observations had taken place in relation to administering medicines, as well as other areas of

care such as mealtime assistance and infection prevention and control. The records we inspected showed staff had been given feedback. We also saw records of, 'Knowledge/awareness checks,' where staff had been asked to outline their understanding of different areas of care.

We did not see any examples of information being made available to people in adapted formats, such as large print or pictorial for example. Some people, such as people living with dementia for example, may benefit from pictorial information. The manager told us they were aware of this and this was an area they were looking to improve. Following the inspection, the manager forwarded us some examples of information being provided in different formats such as pictorial and communication cards.

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.

We checked whether the service was working within the principles of the MCA. We found DoLS applications had been made and those which had been granted did not have conditions attached.

We saw examples of decision specific mental capacity assessments relating to taking medication, consent to a referral to occupational therapy and for dental work. These established the person lacked capacity to make these decisions and showed best interests decisions had therefore been made. Where a person occupied a shared room and did not have capacity to consent to this, records showed a decision had been made in the person's best interests, taking into account other relevant people's views such as the person's close family. This showed the principles of the MCA had been followed.

However, one person's care record we reviewed indicated the person did not understand the medication they must take. However, there was no mental capacity assessment or best interests decision relating to staff administering medicines. We shared this with the manager and senior carer, who told us the person did understand their medicines and therefore a mental capacity assessment would not be required. We asked the manager to check the person's records to ensure the information was amended to accurately reflect whether the person lacked capacity.

Throughout our inspection we observed staff sought consent from people by asking questions such as, "Can I help you with that?" and, "Would you like me to help?" People told us staff asked for consent and people felt in control of their care and support.

We observed a mealtime experience and this was a relaxed, social occasion. A member of staff noticed a person had not eaten much of their food. The staff member said, "Do you want me to sit with you [Name], whilst you have your lunch?" The staff member then sat with the person, offering assistance and encouragement for the person to finish their meal. This showed people received support to meet their nutrition and hydration needs. We heard one person say, "Tell [name of cook] it's beautiful," in relation to their meal.

Some people chose to take their meals in their own rooms. We saw staff took people their meals and offered condiments and napkins and a choice of drinks.

During our inspection, the usual cook was absent from work. A member of care staff undertook cooking duties. We checked and found this staff member had completed a qualification in food production and cooking, as well as food safety, and they had good knowledge of people's individual dietary needs.

Throughout our inspection, we observed staff asking people whether they wanted any food or drink and people were encouraged when this was appropriate. People's wishes were accommodated. One person said, "I like the food. If there was something I didn't like they would do something else for me."

We observed staff encourage a person to have a drink when they woke in the morning. Staff were heard saying to the person, "You sometimes go dizzy if you don't have a drink first, so why don't you have one?" This showed staff encouraged people with their nutrition and hydration needs.

We observed a person who preferred to sit at a quiet dining table in a lounge area to eat their breakfast. The table was set with appropriate cutlery and condiments and staff asked the person if they needed anything, but left the person to eat independently, which was how the person preferred to enjoy their meals.

One person had recently begun refusing food on multiple occasions. Records showed the person was offered alternatives and the person was regularly weighed. Records showed the person's weight remained stable, despite their refusal of some meals and a dietician had recently visited. This demonstrated staff were working with the person to access appropriate health care to address this.

We looked in the kitchen and found plentiful stocks of fresh food and drink. All the staff we asked told us there were sufficient supplies of food and people could make their own choices.

We looked at the design of the premises. We saw people's rooms were personalised and contained photographs and items of sentimental value. Communal areas were decorated in traditional, homely styles and this was in keeping with the relaxed, informal atmosphere at the home. However, we reported at our last inspection the home would benefit from some refurbishment and the design of the home was not suited to people living with dementia. We found the same during this inspection. Environments can be made more suitable for people living with dementia by giving consideration to contrasting colours and signage, for example.

We recommend the registered provider access national best practice guidance relating to developing appropriate environments for people living with dementia.

On the first day of our inspection we observed a handover meeting between the night staff and day staff at the home. Relevant information was shared between staff, which helped to ensure people received continuity of care.

We observed staff ask a person if they wanted a doctor to be called, when the person was unwell. The person declined and this was respected, although staff later asked the person again. Records showed referrals had been made to a range of health care professionals, when this was appropriate, such as opticians, chiropodists, district nurses and GPs. This showed people received support in order to have their wider health care needs met.

Good

Our findings

People told us staff were caring. One person said, "I really feel that the staff do care about me, yes." Another person said, "Yes, the staff always treat me with kindness and respect. My visitors are always made to feel welcome." A third person told us, "Staff always treat me with respect."

Our observations throughout our inspection were that there was a mutual respect between staff and people living at the home. Many respectful interactions were observed and heard. Care staff were motivated to provide good care. One staff member told us, "I love it. I love looking after people."

On the first day of our inspection we arrived to speak with night staff. We observed as each member of day staff came on shift, they acknowledged and chatted with people as soon as they arrived at the home, and asked if anyone would like a drink, even though most people already had a drink.

A person living at Lyndhurst was independent, although a little unsteady on their feet. On the first morning of our inspection, we observed a member of staff offer to assist the person. The member of staff asked the person if they would like assistance, and then asked the person which side they wanted the member of staff to stand and how they would like assisting. The person was able to tell the staff member how they would like supporting. Even though the staff member knew the person well, this showed they encouraged the person to maintain their independence, whilst providing appropriate support.

Staff and the manager were seen to communicate effectively with people. Appropriate touch and tones were used to reassure people. We observed staff and the manager kneeling to people's eye level when speaking with them. This showed staff and the manager demonstrated good communication techniques.

People were encouraged to wear appropriate clothing such as slippers for around the home, and coats when people were going outside. Staff suggested people may be comfortable with a blanket when they were sat still. This showed staff cared and pre-empted people's needs to keep people warm and comfortable.

We observed one person woke and rose much later than most other people in the home, that is, after people had finished eating their lunchtime meal. As soon as the person entered the communal area, they were welcomed and staff identified the person may want something to eat. A staff member prepared some food for the person and assisted them to eat in a kind and caring manner.

We observed a member of care staff assisting a person to eat their meal. The member of staff reminded the

person what they were eating and asked, "Is that okay?" The person was assisted at their own pace and the staff member was focussed on the person throughout their meal, in a kind and caring way.

We observed a member of care staff assisting a person to eat their meal. The staff member placed the food on the person's spoon and then placed the spoon in the person's hand, encouraging the person to eat independently.

The manager told us there was no one living at the home who had any specific religious or cultural needs. They told us people were treated as individuals and their individual preferences were respected. We asked the manager how they knew whether people's diverse needs were met and the manager told us they spoke to people about their needs. However, we advised the manager we felt more information could be captured about people's specific needs and incorporated in their care records. The manager agreed to consider this further.

We asked staff how they ensured people's diverse needs were met, in terms of their cultural, religious or sexuality needs for example. Staff told us they would read people's care plans and talk to people to find out their needs. Through our observations and speaking with people and staff, it was clear staff knew people well.

One person's spouse spent most of the day at the home. They sat in the person's room, spending time together. One person told us, "My family come to see me all the time and they [staff] are very nice to them." A relative told us, "Yes, I'm able to visit anytime. I just bob in. There are no restrictions." This showed visitors were welcome at the home and people were able to maintain contact with those important to them.

We observed staff respected people's privacy, such as by knocking on doors. One person told us, "They're very careful about closing the door and covering me." A relative told us, "I'm absolutely convinced that they are respectful of my mum's privacy and dignity."

We observed a member of staff ask a person if they would like to assist with washing up. The person was keen to undertake the task. This meant the person was able to retain their daily living skills and retain a level of independence.

One person's care plan indicated staff should prompt a person to change their clothing, should this become dirty. We observed staff do this in a manner which was respectful and encouraged the person to retain their independence and their dignity.

No-one living at the home was receiving support from an advocate at the time of our inspection. However, we noted leaflets for an advocacy service were displayed and people had previously benefitted from advocacy. An advocate is a person who is able to speak on other people's behalf, when they may not be able to do so, or may need assistance in doing so, for themselves.

Requires Improvement

Our findings

People told us they felt they had choice and control. One person told us, "Yes of course I have choice of my daily routines."

Upon early arrival on the first day of our inspection, two people had already risen for the day. They both told us they liked to wake and rise early and they were sat having a hot drink with staff.

We inspected four people's care records. These contained a photograph of the person and detailed information relating to the person's history and family. Plans contained specific information relating to people's preferred routines. For example, one record stated, 'I like two cigarettes with my first cup of tea in a morning.' We observed this and the staff we spoke with were clearly aware of the person's preferences.

Care records contained information relating to people's needs in areas of care such as physical wellbeing, mental health, personal care, eating and drinking, oral care, mobility, continence needs, communication and sensory needs. This enabled staff to provide appropriate care and support.

The manager told us care plans were reviewed monthly, and most of the records we reviewed confirmed this, although two records were last evaluated in September 2017. Records did not evidence people had been involved in reviews of their care needs, other than those relating to activities. The people we spoke with also confirmed this. Further, we found care records lacked information relating to people's cultural, religious or sexuality needs. We shared our findings with the manager who was receptive to this and agreed to further consider how this could be improved.

The plans we reviewed included hospital passports and these contained detailed information. The aim of a hospital passport is to provide hospital staff with important information about a person and their health when they are admitted to hospital. Having a hospital passport can make hospital visits less stressful for people because health care staff are made aware of their needs and preferences.

Although one person had an allotment style area of garden which they enjoyed tending to, we found a lack of meaningful activities and occupation at the home and this was also found at our last inspection. Some people and some staff we spoke with confirmed they also felt there was a lack of activities. There was no dedicated member of staff for activities provision.

There was an activities planner file which contained forms to record information relating to the activities

people enjoyed. However, records were incomplete and activities were not recorded for at least 14 days in November in the eight records we sampled within the file. Another person's record of activities we reviewed showed only 16 entries made during October and these consisted of, 'Watch TV,' and, 'Chat to staff' only. This further demonstrated a lack of meaningful activities for people.

We highlighted our concern to the manager and they advised there was a 'clothes party' the following day. However, they confirmed they would be considering further activities provision.

People were encouraged to maintain relationships with people who mattered to them. We overheard a senior carer speaking with a family member on the telephone. The senior carer provided the family member with information regarding their relative and then we heard the senior carer say, "Would you like to speak with [name of relative]?" This showed the senior carer was encouraging family contact.

People told us they could make their own choices. One person told us, "They [staff] ask what I'd like to wear in a morning. I'm not bothered, I'll wear anything, but they always ask." We were told by a further person, "Yes I do have control of what I want to do and where I want to be." Another person said, "Staff always listen to me and absolutely respect my choices."

Staff told us people could choose when to retire to bed or when to rise. People chose where they wanted to take their meals. We heard a member of staff say to a person, "[Name], would you like your lunch in here [the person's own room] or in the dining room?" The person's wishes were accommodated.

The home had a number of washrooms with toilets, but only one bathroom in use which people could use to bathe and this room did not contain a shower. This meant people could not choose to have a shower if they wanted. We were told at the last inspection that a further room was being considered for a shower. However, this had not yet materialised.

The complaints policy had been reviewed during November 2017. A formal complaint had been received and records showed the previous manager had taken action to resolve the issue. People we spoke with all indicated they would know how to complain.

We looked at whether appropriate end of life care provision was in place. End of life care was not being provided at Lyndhurst at the time of our inspection. However, we noted care records contained little information in relation to people's end of life wishes and preferences. We shared this with the manager who agreed to give this further consideration.

Requires Improvement

Our findings

The manager of Lyndhurst had been in post for four weeks prior to our inspection. They had previously worked at Lyndhurst and they told us they felt supported by the staff already established at the home. It was clear the manager had a good rapport with people living at the home and knew people's needs well.

All of the staff we spoke with told us morale had recently improved at the home, since the appointment of the new manager. One staff member said, "The mood has lifted." Another member of staff told us, "The team are really good. We all work together. There's no atmosphere." A further member of staff said they felt the new manager was, "Approachable and hands on." All of the staff we asked told us they would be happy for a relative of theirs to live at the home.

We asked staff about the culture of the home and whether they felt able to raise any concerns. All of the staff we asked told us they did not have any concerns currently but, if they did, they would feel confident to raise them with the manager. Staff were aware the manager had introduced a system for staff to share any concerns if they wished. This showed the manager was trying to embed an open culture within the home, where staff would feel safe to raise any concerns or issues.

The manager told us they felt supported by the registered provider and they felt they would have access to the resources required, in order to improve the home further. The registered provider had engaged a consultant to help drive improvements at the home and the new manager told us they were working together to make this happen.

The new manager of Lyndhurst was also the registered manager of a domiciliary care agency, which was owned by the registered provider. The registered provider had advised us that the manager intended to de-register as manager of the domiciliary care agency, if their application to become registered manager of Lyndhurst was successful. The manager had taken steps to apply to become registered to manage Lyndhurst, although this was ongoing at the time of this inspection. The manager continued to provide support to the domiciliary care agency. We discussed with the manager the need for their time and resources to be dedicated to Lyndhurst Residential Home, if the home was to continue to improve.

A member of staff told us a meeting had been held with staff when the new manager came into post. They told us the registered provider attended and asked staff if they had any concerns. Meetings are an important part of a manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Regular meetings were not held with either the people living at Lyndhurst or their families. A relative told us, "We don't have such meetings. We do get together at the social events like the Easter eggs thing and I can always speak to the manager or the senior carer about anything." A member of senior care staff told us there was a plan in place to introduce house meetings although these were not yet established.

We saw people had completed some questionnaires in relation to the quality of their mealtime experience. The food, service and environment were rated on a scale of one to five. We reviewed ten recently completed questionnaires and these showed people had scored each category a minimum of four. This showed feedback had been sought from people and this feedback had been positive.

Some people living at the home had been involved in asking questions of potential new employees. This showed some people were involved in some decision making processes at the home.

The previous manager, who had now left employment, had undertaken some audits in relation to the environment. These had identified new carpets were required in communal areas, such as hallways. However, the audits of March, July, August and September 2017 indicated, 'carpets need replacing,' indicating these areas identified had not been actioned. This meant the audits were not always effective at improving the quality of service. The manager told us they would raise this with the registered provider.

An audit of first aid boxes was carried out during August 2017 and this identified stocks needed replenishing. However, at the time of our inspection, the first aid boxes did not contain many of the items listed on the first aid checklist. This indicated the audit had not been effective in improving the safety and quality of care provision. We advised the manager to take immediate action to replenish stocks.

The above demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems in place to assess, monitor and improve the quality and safety of the service were not always effective.

A 24 hour audit tool was used to audit medicines. Records showed regular checks were made in relation to storage and recording of medicines. Additionally, monthly medication audits were completed and these checked storage, completion of medication administration records, stock control of medicines and recording of incidents.

We saw a Residents' File Audit, dated October 2017, identified some areas for improvement, such as recording of information and these were actioned. In the files we reviewed we saw the information was included, which showed the audit had been effective in improving care records. Other audits such as those relating to mattresses, infection control and the kitchen were also undertaken regularly.

Up to date policies and procedures were in place, such as those in relation to safeguarding, health and safety, medicines and infection prevention and control. Having up to date policies and procedures in place help to ensure current, up to date, guidelines are followed.

The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems in place to assess and monitor risks relating to health, safety and welfare of people 17(2)(b). Accurate, contemporaneous records were not always kept in relation to people's care and treatment 17(2)(c). Systems in place to assess, monitor and improve the quality and safety of the service were not always effective 17(2)(a).