Lyngate Healthcare Ltd

Lyngate Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The unannounced inspection took place on 10 August 2016. The last inspection was undertaken on 25 July 2014 when the service was found to be meeting all requirements reviewed at that time.

Lyngate Care Home is registered to provide accommodation for up to 41 adults requiring personal care. The home is situated on a busy main road in the Deane area of Bolton. There are car parking facilities to the rear of the building and there is good access to local amenities. On the day of the inspection there were 34 people using the service.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to staffing, safe care and treatment, meeting nutritional and hydration needs, need for consent, dignity and respect, person centred care and good governance.

Staffing levels were inadequate to meet the needs of the people currently using the service. There were some safety hazards, such as a long trailing buzzer cord and a call buzzer which was out of reach of people who used the service. Individual risk assessments were not always meaningful in terms of actions required to minimise the risk and the information in people's care files was not always completed.

The staff recruitment and induction processes were satisfactory and staff training was not up to date but there were plans in place to rectify this. Supervisions and appraisals were not carried out on a regular basis.

There was a safeguarding policy in place and staff were able to explain how they would recognise and report any concerns. Safeguarding issues raised had been followed up appropriately.

All health and safety processes, such as electrical and gas safety, fire equipment maintenance and checks and environmental maintenance and checks were in place at the service. There were systems in place to help ensure medicines were ordered, stored, administered and disposed of safely.

There was a lack of choice with regard to meals and food and fluid charts were not always completed. People's preferences, choices, likes and dislikes were not consistently recorded and people were often unable to have their choices respected due to the low staffing numbers.

Some people who used the service were poorly presented and records indicated they were not being supported to have baths and showers on a regular basis. The building was over three floors and was difficult for people to navigate around without support.

Staff had a basic understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) but information in care files was not robust in regard to these issues. There was a complaints policy in place and no complaints had been received recently. No staff meetings where staff could voice their opinions or raise concerns were taking place.

The registered manager was not visible around the home and staff said they would raise any concerns or issues with the deputy managers. We saw medication audits but there was no evidence of other quality audits. Regular surveys were completed with people who used the service and their relatives. Many of the policies at the service required updating.

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 safe.

Staffing levels were inadequate to meet the needs of the people currently using the service. There were some safety hazards at the service. Individual risk assessments were not always meaningful in terms of actions required to minimise the risk.

The staff recruitment process was satisfactory.

There was a safeguarding policy in place and staff were able to explain how they would recognise and report any concerns. There were systems in place to help ensure medicines were ordered, stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

The service was not effective.

Staff induction was satisfactory. Staff training was not up to date and supervisions and appraisals were not carried out on a regular basis.

The information in people's care files was not always completed.

There was a lack of choice with regard to meals and food and fluid charts were not always completed. Staff had a basic understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not caring.

People who used the service were poorly presented and looked unkempt and uncared for.

Records indicated that people were not being supported to have baths and showers on a regular basis.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's preferences, choices, likes and dislikes were not consistently recorded. People were often unable to have their choices respected due to the low staffing numbers.

There was a programme of organised activities at the home but there was little one to one interaction between staff and people who used the service.

There was a complaints policy in place and no complaints had been received recently.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager was not visible around the home and staff said they would raise any concerns or issues with the deputy managers.

There were no staff meetings where staff could voice their opinions or raise concerns.

We saw medication audits but there was no evidence of other quality audits.
Regular surveys were completed with people who used the service and their relatives. Many of the policies at the service required updating.

Lyngate Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 10 August 2016 and was unannounced.

The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC).

Prior to the inspection the service completed a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service. We also reviewed information we held about the home in the form of notifications received from the service and contacted Bolton local authority and the local Healthwatch to gain their views and opinions about the home.

As part of the inspection we spoke with the directors, registered manager, the two deputy managers, four members of care staff, nine people who used the service and two relatives. We observed care throughout the home during the day. We looked at four care plans and four staff files. We also reviewed other records held by the service including audits and training records.

Requires Improvement

Is the service safe?

Our findings

We arrived at the home in the early morning and walked around the premises. We found the home to be clean and there were no malodours detected. At the start of the day staffing consisted of the registered manager, deputy manager and two care staff caring for 34 people using the service over three floors. There was also a cleaner, laundress, cook and kitchen assistant and handyman. The provider arrived later in the morning.

We looked at staffing rotas which indicated there were three care staff along with a deputy manager and the registered manager each day to attend to people's needs. We were told when we arrived that a staff member had rung in sick and the service would also be short the following day. When the provider arrived they discussed the staffing situation with the registered manager and cover for the following day was arranged. Two more care staff came on duty in the afternoon and another deputy manager arrived at the service after lunch, who told us they had been passing, had called in and decided to stay and help.

One staff member we spoke with told us, "Sickness and holidays affect staffing levels". Another said, "Even fully staffed there are not enough", and a third commented, "There are not enough staff".

One person who used the service said, "Definitely not enough staff. There are usually only two staff on. I need to go to the toilet urgently and usually have to wait a while [after using the call buzzer] for staff to take me". A second person said, "Never enough staff". Another told us they felt more staff were needed. One person who was more independent and did not require full support felt there was not a problem with staffing.

Throughout the day we observed occasions when there were insufficient staff to meet the needs of the people who used the service and people were left unsupervised for long periods of time. For example, we saw people who had been got up late being brought for breakfast at 12.30 pm and left with a bowl of cereal in front of each of them. One person sat with the cereal in front of them for an hour and no assistance was offered as no staff were in the room. One person managed to get some milk on a spoon but ate none of the cereal. When staff brought them into the dining room we asked why these people were just getting their breakfast and the staff member replied, "We have just got round to getting them up and dressed". The staff member felt this was due to the staffing levels on the day. However, the registered manager and the deputy had attempted to encourage these two individuals to get up earlier, but they had refused. When lunch was served the cereal was removed and a sandwich was placed in front of the two people.

We saw staff taking regular smoking breaks throughout the day. At one point in the afternoon three staff members were outside having a break together, meaning there were few staff left around the building to attend to people's needs. Staff were on the middle floor, though there were people who used the service in their bedrooms on the upper floor and two people sitting in the lounge on the lower floor.

We looked at care plans and saw that three out of four people whose files we looked at required two staff for personal care interventions, such as washing, dressing, assisting to the toilet, and transferring. This would tie

up two staff at once, leaving other people who used the service with little or no supervision and assistance. The dependency tool used to inform staffing levels to ensure people were receiving the correct level of care required updating to ensure that sickness and holidays were managed more effectively.

This was a breach of Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with the provider about the staffing levels at the service. They told us they were in the process of recruiting more staff and would re-assess the number of staff required on a daily basis. Following the inspection we asked the provider to provide an explanation of how staffing levels were calculated. The provider supplied information about the model used which was based on numbers of hours to numbers of service users and 'high dependency' service users. However, from our observations on the day of the inspection staff were unable to meet the needs of the people who used the service.

We saw in the lounge on the lower floor that a call buzzer with a long wire was stretched across the lounge floor and then tied around the chair arm, in order for a person who used the service to be able to use it. This was a tripping hazard and we spoke with the provider about this. They told us they had suggested the person sit at the other side of the lounge, but they did not wish to sit elsewhere as they would be unable to see the TV or sit next to their friend. We asked the provider to ensure this was made safe immediately, which they agreed to do.

The call bell in the toilet near the front door was tied up and out of reach. This meant that, in the event of someone using the toilet and having a fall, they would be unable to pull the call bell to summon assistance.

On the middle floor the dining room led out to a pleasant conservatory area. However, there was a small step to negotiate to get from one room to the other and this was a tripping hazard for people who used the service if they tried to move around without support.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

In the four care files we looked at we saw that there were a number of individual risk assessments in place. However these were not always meaningful in terms of actions required to minimise the risk. For example, risk assessments such as mental health, physical health, falls were given scores which resulted in the risk being evaluated as very heavy, heavy, medium or low. However, some scores were the same but resulted in a different evaluation. When scores came out as heavy or very heavy the provider told us that equipment, such as pressure mats, was put into place. However, this was not recorded in the care plans.

There was a main file containing Personal Emergency Evacuation Plans (PEEPs) which outline the level of support people need in the event of an emergency evacuation. These were complete and up to date.

Accidents and incidents were recorded in some detail. However, there was a need to follow up the reports with actions. For example, putting equipment in place or changing the care plan to reflect the new level of assistance required.

We looked at four staff files and saw that recruitment was satisfactory. Employees had Disclosure and Barring Service (DBS) checks in place. These checks help ensure that people are suitable to work with vulnerable people and have not been barred from doing so. Some of these checks had not been renewed for a long period of time, up to ten years in some cases. It would be good practice to regularly update these

which we discussed with the provider.

We looked at the health and safety records and saw that matters such as the maintenance and annual servicing of equipment was up to date. Gas and electrical safety certificates were also in place. Fire equipment inspections and maintenance of fire equipment were carried out appropriately.

The service had a policy in place relating to safeguarding vulnerable adults, but this was in need of updating. Staff we spoke with demonstrated an understanding of safeguarding issues and who they would report any concerns to. Care staff told us they would always report to the deputy managers. Safeguarding concerns raised had been followed up appropriately by the provider.

We looked at the medicines policy and were shown the systems used by the service by one of the deputy managers. The medicines policy included guidance on covert medicines, that is medicines given in food or drink, homely remedies and topical applications. However, the policy was in need of updating as some of the contact details were out of date.

There were safe systems in place for the ordering, storage, administration and disposal of medicines. We found that medicines, including controlled drugs, were securely stored, with limited stock and recorded and signed for correctly when given. Fridge temperature records were recorded regularly and were within the manufacturer's recommended range.

We saw that regular audits were carried out on Medication Administration Record Sheets (MARS) to help ensure there were no missing signatures, medicines that had been missed or other errors. We also saw evidence of competence checks undertaken by senior staff on those dealing with medicines to help ensure their practice and skills were kept up to a good standard.

Requires Improvement

Is the service effective?

Our findings

We looked at four staff files and saw that staff had completed a basic induction programme prior to commencing work at the service. We looked at the training matrix and staff certificates and saw that training was not up to date for all staff. Some staff had completed training in safeguarding, Mental Capacity Act, dementia awareness and dementia and nutrition, some had completed moving and handling theory but we could not see evidence of the practical application of this training. The provider explained that they had recently started to use a private trainer and showed us a plan for training to be undertaken in the next few months.

We asked staff if they felt there was enough training offered to them. One staff member said, "There is enough training. I like doing all that". Another staff member, when asked about dementia training, told us, "I have only had three hours dementia training and need more. I am keen to do more training".

We looked at records of staff supervisions and appraisals which were ad hoc. Some people had been given informal supervisions, others formal ones, but none had been carried out with any frequency. For example, two staff had been supervised informally once in 2016, two staff members had not had an informal supervision since 2015. Only one person had been supervised formally in 2016. One person had had an appraisal in 2015 and one in 2016. Four other records of appraisals were seen but these were undated.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at care files for four people and found that, although there was some good information within files, some of the care plans and risk assessments were not complete. Risk assessments, such as falls, physical health, nutrition, moving and handling, skin integrity and behaviour indicated whether the risk was low, medium, heavy or very heavy, but this was inconsistent within files. It was unclear what these ratings meant in terms of providing appropriate care and support for the individual. We asked staff for clarification of what the ratings meant but they were unable to explain them. The provider could not explain the ratings either.

We asked people if they enjoyed the food at the home. One person said, "You can have what you want. I've had a bacon buttie. I enjoy the food". Another told us, "If you don't like the meal you can have something else. I'm having brunch today as I stayed in bed late".

The breakfast menu was displayed in the dining room, but was not big enough for people who used the service to read. We saw that most people had cereal and toast, though there were two people, with capacity, who had asked for a late brunch and we saw this being taken to them. The two individuals who had awoken late had cereal. The deputy manager confirmed these individuals may have had supper, but had not had a proper meal since the previous tea time, which could compromise their well-being. The provider told us they had refused food and drink in their rooms that morning. The deputy manager told us they were concerned about one of the individual's nutritional intake. The provider policy was that if concerns were raised about

lack of hydration and nutrition a food and fluid chart should commence, but this had not been implemented. This person's care file had documentation that the person had lost 2 kilos in a month and stated a referral to a dietician should be made. There was no evidence of a referral or follow up actions taken.

Lunch consisted of a bowl of mushroom soup and a slice of bread and butter. This was followed by fruit cocktail and cream. One person, who was able to say they did not want mushroom soup, was offered a tin of vegetable soup as an alternative, but there were no choices automatically offered to people. Staff assistance at the meal was minimal. People were dining in different parts of the building, so staff had to go from room to room to serve food.

We asked to look at menus but were told the service did not work to a menu cycle; the registered manager planned the meals on a weekly basis and told the chef what to take out of the freezer for each day. The teatime meal was pork casserole and again there were no choices automatically offered. However, the provider told us that staff were aware of people's preferences and would give an alternative to those who were unable to articulate their choice. We saw that there was fresh fruit in the kitchen.

We looked at food and fluid charts for people who were being monitored with regard to nutrition and hydration. These had not been completed accurately and there were gaps where information was missing. This could have compromised people's well-being with regard to nutrition and hydration.

This was a breach of Regulation 14 (1) (4) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The building was over three floors and was difficult for people to navigate around easily. This, combined with the low staffing numbers, meant people were often left sat at the dining table, or in bed, for considerable lengths of time whilst waiting for someone to support them to move around. People whose rooms were on the top floor were brought down to the lounge on the middle floor and were unable to return to their rooms, without support, should they wish to.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. With regard to best interests, this was covered appropriately within documentation referring to DoLS. However, there was no documentation within care files which referred to best interests in other areas. For example, we saw that some care files included consent forms for subjects such as consent to medicines administration. Some had been signed by the person who used the service, if they had capacity to do so. In other files these consent forms had not been signed and there was no explanation as to why the person had not signed, for example, if they did not have mental capacity. There was no documentation to demonstrate that the decision had been made in the person's best interests as required by MCA.

This was a breach of Regulation 11 (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff spoken with demonstrated a basic understanding of mental capacity and were able to explain about how they supported people to make choices. DoLS applications were made appropriately and currently thirteen people were currently subject to DoLS at the home. However, we did not see documentation within care plans to guide staff on what this meant for each individual in a practical way, i.e. how people were kept safe in the least restrictive manner.

Requires Improvement

Is the service caring?

Our findings

One person we spoke with said, "They look after me well – can't grumble". Another told us, "They [staff] are all lovely, they are very kind here". We spoke with two relatives who were visiting the service. Both were happy with the care their loved ones were receiving and had no concerns.

We asked if the provider if any residents' and relatives' meetings had been held. They told us there had not been any residents' and relatives' meetings, but documentation was supplied to demonstrate that residents' meetings took place on a regular basis. We asked the provider if there was a service user guide produced by the service but they said there was not. We looked in the care files and saw there was little evidence of involvement in care planning by people who used the service or their relatives.

People who used the service were not well presented and we saw that their dignity was compromised. More than one person had long dirty finger nails and hair in poor looking condition. Some of the gentleman had not been shaved that day, though this may have been by choice, and at least two of the ladies were seen to have facial hair. This demonstrated a lack of basic care and attention. We mentioned that some ladies looked as though they had not had their hair brushed and pointed out one particular individual to the provider. They agreed that the individual looked dishevelled.

We looked at the bath/shower book, where baths, showers, strip washes and nail care were recorded. Documentation indicated that people were having baths, showers and strip washes on a less than monthly basis. According to the records one individual had not had any baths, showers or strip washes in 2016. One person had been bathed twice in January 2016 and not since, six people had been bathed or showered once in February 2016 but not since, five people had been bathed twice in 2016, eight people had been bathed three times in 2016 and one had been bathed four times in 2016. Only four individuals had been bathed or showered on a regular basis. These were people who were able to articulate a desire to have a bath or shower. The records indicated that one person had had nail care on one occasion. We spoke with the provider about this and they felt the documentation was poor and told us the baths and showers would be recorded in the daily records. We checked this but found no records of baths in the daily records we looked at. Staff we spoke with confirmed that they did not have time to bath people due to the low staffing levels at the service.

This was a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed care within the home during the day and, although staff were kind, we saw little interaction between staff and people who used the service. We saw that people were being left in wheelchairs for long periods of time. We discussed this with the provider who felt that constantly moving people via hoist and stand aid was invasive and that transferring people less often was in their best interests. However, this should be properly assessed and documented for each individual to ensure this was indeed in their best interests. We saw one individual sitting at the dining table in their wheelchair and sliding down, which made it difficult for them to reach their food. Another person was brought into the room in a wheelchair and told

by a member of ancillary staff, "The girls will come and put you in your chair". This was at 3.55 pm and the individual was still in their wheelchair at 4.45 pm. A comment was made by staff that they were going to have tea now so there was no point in moving them.

Requires Improvement

Is the service responsive?

Our findings

We asked people if their wishes and preferences were respected. One person who used the service told us, "I go to bed at 3.30 pm because I get sore sitting in a chair. I would like to get up for tea, but the staff are too busy so I stay in bed". We spoke with the provider about this and they agreed to look into facilitating some bed rest in the afternoon whilst respecting the person's wish to get up again for a few hours around tea time.

We looked at care plans for four people and saw that pre-admission assessments were basic, with little meaningful information. Reviews of care plans and risk assessments were undertaken regularly and we saw records of professional and social visits to each person.

Some care files included a life history of the person and there was some reference to people's preferences and choices. However, this was not consistent and some care plans had no reference to preferences, likes and dislikes. Personal histories had not always been completed, but the provider told us this was because some families had chosen not to complete these. Where possible personal histories were completed by staff with the individual who used the service. Choices people made, such as preferred times of rising and retiring, where people wanted to be in the home at any given time and what they wanted to do was dependent on there being enough staff to offer these choices. We saw on the day of the inspection that these choices could not be respected due to the lack of staff around the home. Individuals had stated whether they would prefer a bath or a shower but records indicated that showers and baths were not happening regularly for the vast majority of people who used the service.

This was a breach of Regulation 9 (1) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw that entertainers visited the home regularly and the service employed an activities coordinator to organise games and activities within the home. There was a programme of organised daily activities, such as Holy Communion, quizzes, quoits, picture bingo, music for health, armchair bingo and memory games, which were arranged for Mondays, Tuesdays and Thursdays. A poster advertising these events and announcing birthdays of people who used the service was displayed in the home.

On the day of the inspection the activity coordinator was busy serving drinks so there were no activities until late afternoon, when a game of throwing a bean bag on to a floor target commenced. We did not see any one to one conversation between people who used the service and staff members. However, documentation was provided that demonstrated some one to one activities occurred between the activity coordinator and people who used the service, on a regular basis. The weather was sunny and warm but only one person was seen to go outside to sit in the sunshine. Individuals who required assistance were not helped or encouraged to go outside.

The provider had a complaints policy and we saw that no complaints had been made in the last year. Some compliments had been received by the service in that time. Feedback from people who used the service had indicated that they were unaware of how to make a complaint. We saw that the service had responded to

this by placing a poster in the downstairs corridor, with an easy read version of the policy outlined on it. This would help ensure people were able to express their concerns in the correct way if required.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place at the home. However, the inspection was facilitated by the providers, who were a regular presence within the home.

We observed throughout the day that the deputy managers took on most of the responsibility for the day to day running of the home and this was confirmed by the paperwork we saw, which had been completed by the deputy managers. We spoke with the providers about the management of the home and they told us they intended to review the management structure to include a supernumerary assistant manager position.

We asked staff if they were well supported. One staff member said, "There is not enough support. No thank yous for doing extra shifts and no supervisions or appraisals". Another told us, "We are supported well by the deputies". All staff we spoke with told us they would raise any concerns or discuss any issues with the deputy managers.

We saw no evidence of staff team meetings taking place and we asked the provider if these occurred. They told us they did not have team meetings. These would have provided a forum where staff could raise any concerns or discuss any issues they may have. Supervisions and appraisals, which provide an opportunity to look at staff performance and development and plan further development opportunities, were inconsistent. This meant that staff had few formal opportunities to discuss voice their opinions. The provider told us they were available for staff to approach informally whenever they were on site and the registered manager and deputies were available at other times. Staff confirmed that they talked to the deputy managers on a day to day basis, but told us they would probably not approach the provider or speak with the registered manager if they had concerns.

We saw that regular medication audits took place at the home and care plans were audited on a regular basis. However, we did not see any other quality audits which would have helped ensure continual improvement to service delivery.

There were appropriate policies and procedures in place at the service. However, many of these had out of date contact details in them so all policies were in need of reviewing and updating to ensure these details were current.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider was involved with the local Care Home Providers' meetings and received minutes of their regular meetings. This was a forum where general issues could be debated, speakers often attended to share new information and best practice was discussed.

A survey had been completed with some people who used the service and by some of the relatives in 2016. Comments from people who used the service included; "Some staff are good, some less"; "Some staff are approachable but I'm not sure who I would make a complaint to"; "I'm quite happy", and, "Some days are

better than others. There are days when staff are stressed". Comments from relatives included; "Could be better, no time for staff to talk to people", and, "Pleased with home". We saw that the service had responded to the comments with the addition of the easy read complaints procedure to help ensure people knew how to raise a concern.