Bupa Care Homes (ANS) Limited

Lynton Hall Care Home

Inspection report

2 Lynton Road
New Malden
Surrey
KT3 5EE

Tel: 02089491765
Website: www.bupa.co.uk

Date of inspection visit:
18 July 2017

Date of publication:
11 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 18 July 2017. At our previous inspection in 5 March 2016 the service was rated as Good.

Lynton Hall Care Home provides accommodation and nursing care for up to 57 older people. There were 43 people living at the home when we visited. The home was based on two floors, the ground floor for people with nursing care needs and the first floor for people living with dementia. There were bedrooms, bathrooms and communal rooms on both floors.

The home had a manager at the time of the inspection, who was in the process of registering with the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provider did not have suitable arrangements to protect people against the risks associated with the management of medicines. We found that not all medicines were administered safely and the stock control checks of medicine were not always correct. Staff did not follow the National Institute for Health and Care Excellence [NICE] guidelines for the recording of medicines taken or refused. Medicines were stored securely and staff received annual medicines training.

We observed and we received feedback from staff and relatives that there were insufficient numbers of staff to care for and support people to meet their needs. People had to wait for staff to help them with their personal care. We observed one person waited 50 minutes to transfer from their wheelchair to a comfortable chair in the lounge area. We saw that the provider's staff recruitment process helped to ensure that staff were suitable to work with people using the service.

At this inspection we found the provider did not have effective systems to assess, review and manage risks to ensure the safety of people. Although the home conducted a variety of audits they were not effective in that they had not identified the inconsistencies we found in relation to the management of medicines. We saw that regular checks of maintenance and service records were conducted to ensure these were up to date.

The provider took appropriate steps to protect people from abuse, neglect or harm. Training records showed staff had received training in safeguarding adults at risk of harm. Staff knew and explained to us what constituted abuse and the action they would take to protect people if they had a concern. Staff were familiar with risks people faced and knew how to manage these.

Staff had the skills, experiences and a good understanding of how to meet people's needs. Staff spoke about the training they had received and how it had helped them to understand the needs of people they cared for.

The service had taken appropriate action to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. DoLS were in place to protect people where they did not have capacity to make decisions and where it is deemed necessary to restrict their freedom in some way. We saw and heard staff encouraging people to make their own decisions and giving them the time and support to do so.

Detailed records of the care and support people received were kept. People had access to healthcare professionals when they needed them. People were supported to eat and drink sufficient amounts to meet their needs.

People were supported by caring staff and we observed people were relaxed with staff who knew and cared for them. Personal care was provided in the privacy of people's rooms.

People's needs were assessed and information from these assessments had been used to plan the care and support they received. People had the opportunity to do what they wanted to and to choose the activities or events they would like to attend.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People told us they felt happy to speak up when necessary. From our discussions with the manager, it was clear they had an understanding of their management role and responsibilities and the provider's legal obligations with regard to CQC. The home had policies and procedures in place and these were readily available for staff to refer to when necessary.

We found two breaches of regulations during this inspection, in relation to safe care and treatment and staff. You can see what action we have told the provider to take at the back of this report.

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 as safe as it could be. The provider did not have systems in place to protect people against risks associated with the management and administration of medicines.

There were insufficient numbers of staff deployed to ensure that people had their needs met in an appropriate and timely way.

Risk assessments were undertaken to establish any risks present for people who used the service, which helped to protect them.

Staff were knowledgeable in recognising signs of potential abuse and the action they needed to take.

Is the service effective?

Good

The service was effective. Staff had the skills and knowledge to meet people's needs and preferences. Staff were suitably trained and supported for their caring role and we saw this training put into practice.

People were supported to eat and drink sufficient amounts of their choice to meet their needs. Staff took appropriate action to ensure people received the care and support they needed from healthcare professionals.

The service had taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed.

Is the service caring?

Requires Improvement

We observed the majority of staff treated people with dignity, respect and kindness.

Staff were very knowledgeable about people's needs, likes, interests and preferences.

People were listened to and there were systems in place to obtain people's views about their care. People were encouraged and supported by staff to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not as responsive as it could be. Assessments were undertaken to identify people's needs and these were used to develop care plans for people.

Changes in people's health and care needs were acted upon to help protect people's wellbeing.

People told us they felt able to raise concerns and would complain if they needed to.

Is the service well-led?

Requires Improvement

The provider carried out a range of checks and audits to monitor the quality of the service. However, these were not effective as the provider had not identified the various areas for improvement that we found during our inspection.

The manager had a clear understanding of their roles and responsibilities with regard to the requirements for submission of notifications of relevant events and changes to CQC.

Lynton Hall 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.

This unannounced comprehensive inspection took place on 18 July 2017.This inspection was carried out by one inspector, a specialist advisor who was a Registered Nurse with a background in elderly and end of life care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we had about the service prior to our visit and we looked at notifications that the provider is legally required to send us about certain events such as serious injuries and deaths.

We gathered information by speaking with six people living at Lynton Hall, three relatives, the manager, the regional director and 11 staff. We observed care and support in communal areas. We looked at three care records, 20 medicine administration records [MAR] and three staff records and reviewed records related to the management of the service.

Before the inspection we emailed a questionnaire to seven local authority commissioners of services to ask them their opinion of their clients' care. We received two replies.

Requires Improvement

Is the service safe?

Our findings

Two people we spoke with commented "Yes, they [staff] do everything for you and the night staff are alright. They help me find my bag when I lose it and untangle my jewellery and they put it away neatly for me" and "I'm safe I think, the staff are very good." Another person commented about other residents who walk into their room especially at night and how this could frighten them. A relative told us "I'm terribly impressed by the staff they are competent, very caring, no reason to suppose my family member is not safe." We spoke with the manager about people who wander into other people's rooms at night and they agreed it could on occasions be a concern but people could lock their door if they wanted to. We saw that bedroom doors could be locked from the inside with an easy release catch for undoing the lock.

The provider did not have suitable arrangements to protect people against the risks associated with medicines. We found that not all medicines were administered safely and the stock control checks of medicine were not always correct. We reviewed the balance of 11 medicines belonging to different people who used the service. Of those 11 stock check balances we conducted four were incorrect. One medicine showed 15 tablets in stock but there should have been 16. Another showed one less tablet than reported. We also saw this same person had received an extra dose of a prescribed medicine. Instead of the medicine being given every other day the person had received the medicine on two consecutive days. No explanation was given why this had occurred or the action taken to remedy the error.

On the day of the inspection there were two medicines that were not signed for as having been given although the nurse stated they had administered the medicine as prescribed but had not yet signed the Medicine Administration Record [MAR]. On two occasions in October 2016 a time specific medicine was not signed for as given but again no explanation was given. On another MAR the nurse had recorded the exception code "O" meaning other but there was no explanation given on the back of the MAR chart as to what this meant. Another MAR showed one medicine that was not signed for and no exception code was recorded. The National Institute for Health and Care Excellence [NICE] guidelines recommend 'When recording medicines that have been taken or used, staff in the care home should make a note in the record as soon as the person has taken the medicine, including the date and time and make a note when a medicine has not been taken or used and the reasons why. The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Apart from the errors above we saw that medicines were stored appropriately in medicine trolleys that were locked and fixed to a wall. Controlled medicines, topical medicines, food supplements and dressings were stored securely and appropriately. Medicines were in their original packaging and were dated on opening. Temperatures for the clinical rooms and medicine fridges were checked daily, however, there were two gaps in recording of room and fridge temperatures in one of the two clinical rooms. Staff could not explain why these checks had been missed. Staff were able to explain what they would do if any of the temperatures rose above the recommended values. There were medicines prescribed as PRN (pro re nata meaning 'when necessary') and these had protocols with guidance on their use. We spoke with one nurse about the administration of medicine through a percutaneous endoscopic gastrostomy (PEG) tube. The nurse in charge stated the correct procedure for administering medicines through the PEG tube and was clear on

what the guidelines were. The aim of a PEG tube was to administer food, liquid and medicines for those people who cannot swallow. There was a clear list of all the nurses' signatures at the front of the MAR folder. The current MAR charts were supplied by the supplying pharmacy and were pre-printed. An up-to-date photograph of the person requiring the medicine preceded each MAR chart. All service users that were identified as having an allergy had this recorded on a red sticker at the front of the MAR to alert staff.

Throughout the inspection we saw staff were busy and at times there were insufficient staff to meet people's needs in a timely manner. People and relatives commented on the number of staff and peoples access to a call bell saying "Sometimes there is only one staff member on and two staff have gone for a break," "They [staff] keep you waiting a long time to go to the toilet and sometimes I have an accident, that happened yesterday," "At night you press the orange button [on the call bell], there are two carer workers and a nurse on at night but you can wait up to 20 or 30 minutes but sometimes it's only 5 minutes," "A lot of people sit in the lounge after dinner, there are a couple of buzzers [emergency bells] on the wall, but they are too high up if you can't move from your chair you can't get to it. I can't reach the buzzer in the lounge" and "There are not enough staff, I hear people shouting for help or for water and I have to tell the nurses or no one would go to them."

We looked at the staff rotas for three weeks in June 2017 which showed during the day there were two registered nurses (RN) and eight care workers on duty and at night there was two RN's and four care workers on duty. These staff were divided between the two floors where there were 25 people on the ground floor and 22 people on the first floor on the day of our inspection.

We observed on the ground floor there were insufficient staff to meet people's needs. One person was sitting in their wheelchair from breakfast time until after lunch, they asked to go to the toilet but staff kept saying they were coming but they did not come to assist the person, while we were observing. One person had to wait for 50 minutes for a hoist so they could be moved from their wheelchair into a comfortable chair. Another person asked staff to move them from their wheelchair into a comfortable chair but staff said they had to wait for a hoist to be available, the person said "Just wheel me over to the chair, I don't need a hoist, it's what we did yesterday." The hoist and correct sling arrived after a 15 minute wait. Two staff members stated they felt they needed more staff as there sometimes wasn't anyone available to stay in the lounge with people.

We spoke to the manager and regional director about our findings and they told us about the dependency scoring tool they used to determine the number of staff needed on duty. This tool looked at a number of factors including falls people had had, people's nursing, caring and skin integrity needs. They said they would reassess people's needs and adjust the staff accordingly. The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three personal files of recently recruited staff and saw the necessary steps had been carried out before staff were employed. This included completed application forms, references and criminal record checks. These checks helped to ensure that people were cared for by staff suitable for the role.

The provider helped protect people from abuse. Staff we spoke with were aware and could explain to us what constituted abuse and the actions they should take to report it. Staff understood what whistleblowing meant and the need to report their concerns. Whistleblowing is when a worker reports suspected wrongdoing at work. A worker can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including: if someone's health and safety is in danger. Records confirmed staff had received training in safeguarding adults.

When we spoke with the manager they were aware of procedures in relation to making referrals to the local authority that had the statutory responsibility to investigate any safeguarding alerts. The service had policies and procedures in place to respond appropriately to any concerns regarding protecting people from possible abuse and these were readily available for all staff to read.

Risks to people were being managed so that people were protected and supported. We saw that risk assessments and care plans were appropriate to meet a person's needs, including manual handling, skin and oral health care and nutrition. The risk assessments in the care records were completed and reviewed monthly. The cook showed us a weekly list of people's dietary requirements, including any known allergies. Where risks were identified management plans were in place, which gave details of the risks and the preventative measures to take to help prevent an incident occurring.

Lynton Hall had a full time maintenance person and staff could report any faults with equipment directly to this person and they were noted in the maintenance book and actioned in a timely manner and signed as completed. The service had contracts for the maintenance of equipment used in the home, including the lift, fire extinguishers and emergency lighting. The service had a designated medical waste contractor and medical waste was stored and recorded appropriately. We observed good infection control practices, with staff disposing of soiled materials in a safe way. Staff had received training in infection control and the control of substances hazardous to health (COSHH). Overall the home was clean with no malodours.

A food hygiene inspection in June 2017 gave the kitchen a rating of five, where one is the poorest score and five the highest score. We saw that the kitchen was clean and food stored correctly. The provider had recently replaced the freezers and we saw the temperatures of the fridge and freezers were taken daily and equipment defrosted when required. The temperature of delivered food was also recorded to ensure it was safe for storage and consumption. The temperature of cooked food was monitored to ensure the correct temperature had been reach during cooking. Staff had received training in food hygiene, nutrition and hydration and food safety awareness.

Staff were aware of the fire emergency plans and these were kept up to date. The fire alarm was tested weekly. Fire drills were held every six to eight weeks and we reviewed three fire drill reports which detailed any further action staff needed to take to help ensure people were kept safe during an emergency. The provider had arrangements in place to help ensure continuity of service. Arrangements had been made with the local school and church as well as with neighbours to the home who could help to accommodate people in an emergency situation. These measures helped to ensure people were kept safe in all parts of the home.

Good

Is the service effective?

Our findings

People were cared for by staff who received appropriate training and support. People and their relatives gave mixed comments about staff "They have training to be care workers and can use the hoist efficiently," "They work very hard, you can see the sweat dropping off them," "You have a few bad apples now and then," and "Staff are giggling and talking and they just walk by if it's near the end of their shift. I've heard a person calling out for help and they don't help them." "No I don't think they are well trained enough. They are good on basic things but you often see staff sitting around talking to each other."

Records we looked at showed staff had received the training they needed to care for people effectively. Records showed 78.5% of staff had completed the training as required by the provider. This included behaviours that challenge, care of a person with dementia, moving and handling and pressure ulcer care. Nursing staff also received additional training in pressure ulcer prevention and medicine administration levels one and two. Staff spoke about the training they had received and how it had helped them to understand the needs of people they cared for.

Staff received one to one supervision every three months or more often if needed plus a yearly appraisal. Records we looked at confirmed this. We looked at the minutes of the last two staff meetings and saw that actions from the meetings had been recorded and addressed.

The provider had taken appropriate action to ensure the requirements were followed for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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. DoLS protects people when they are being cared for or treated in ways that deprive them of their liberty. People can only be deprived of their liberty to receive care and treatment when it 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.

The manager explained that where necessary mental capacity assessments had been carried out for people living at Lynton Hall and these had been submitted to the local authority for verification. We saw forms had been correctly completed and the outcome of these referrals retained securely.
But this information was not noted in people's care plans to help staff be aware and informed about the decisions so they could apply restrictions appropriately. None of the staff we spoke with were aware of the DOLS process or knew which people had an active DOLS. One staff member thought that people did not have capacity when they 'couldn't do things for themselves anymore'. One staff member said they 'always had to act in people's best interest'. We spoke with the manager about this and they agreed the outcomes of the DoLS applications were filed separately but in future would be filed in people's care plans.

We saw that staff encouraged people to make their own decisions and gave them the encouragement, time

and support to do so. Many people at Lynton Hall were independent, mobile and could make decisions for themselves as to what they did each day and they did not have their freedom to do things restricted in any way. The first floor of Lynton Hall was specifically for people with a diagnosis of dementia, Alzheimer's or behaviours that challenged and the doors were locked using a number key pad system. Relatives and visitors were aware of this number and could visit at any time. People on the ground floor could exit the building by several doors and could go into the garden independently. The garden was situated next to the home's car park and driveway. We recommend that the provider regularly reviews the safety and security of the garden so that all people can use this facility safely.

People were supported to eat and drink sufficient amounts to meet their needs and staff monitored people's weight, as a way of checking a person's nutritional health. The dining rooms were welcoming and each table was set with cutlery, condiments and a table cloth. We saw that a weekly menu was displayed in the ground floor entrance hall area and in the main dining area, however not on the tables themselves. People could choose to eat in the main dining room, their rooms or the lounge. Family and friends were invited to join people for a meal. People had a choice of two main meals but they could also choose an alternative. We saw that two people had an alternative to what was on offer. People were shown both choices of meal and asked to choose. Four people were being supported with their meal and we saw that staff sat down and spoke to the person telling them about the food they were eating. We saw on display in the main hall a 'Night Bite' menu detailing what people could get to eat after supper was served at 6pm. This included sandwiches, toast, fruit, yoghurts and drinks.

Although the service clearly worked hard at providing people and their families and friends with flexibility and choice regarding meals, the comments and feedback we received from people were mixed. Comments we received included "The food's not too bad. You get a choice," "Food's ok, I wouldn't rave about it, but you do get a choice, although some of the portions are small," "I find the meat a bit chewy" and "Breakfast is the best meal of the day."

At times there were completely opposing views. For example one relative told us, "The cooking is outstandingly good, it's varied. I couldn't criticise the cooking" and a different relative said "The food is awful, just horrible." One person said "They don't normally show us the menu; we are getting the royal treatment today."

We observed that people were not shown the dessert on offer but told what it was verbally. If a person did not respond staff gave the person what they thought they would like. We were told by some people that although there did seem to be a "Night Bite" menu with various options the most they were offered was a biscuit and a hot drink. The registered provider may wish to explore this variety of opinion further via discussions with the catering manager, internal audits and surveys for people and their families.

People were supported to maintain good health and have appropriate access to healthcare services. We saw evidence in the people's care records of people being referred to and receiving access to other healthcare services, for example the GP, who visited the home weekly, speech and language therapist (SALT), occupational therapist (OT), the podiatrist, the optician and the tissue viability nurses (TVN).

We saw evidence where staff had worked with other healthcare professionals to monitor a person's personal needs and promote their continence and independence. Staff told us that they could also access the local NHS Nursing Impact Team, who support care homes with nursing needs and training. We also saw evidence of referrals to hospital specialist and the appointments attended.

Requires Improvement

Is the service caring?

Our findings

People told us "There are a lovely lot of people here. I'm getting used to the different things, the meal times. I like it here," "Staff are all terribly caring. One or two residents can be awkward but I've never seen anyone [staff] bad tempered or cross, they are exemplary" and "We have a lot of new young girls [staff] they do their best, but they can't stay very long to chat because the buzzer keeps going and someone else wants them." Relatives commented "Staff are so kind, the staff knowledge of my family member is good," "There's not enough staff just to sit and chat to our family member but they [staff] seem to have enough time to talk to one another," "On the whole staff are very nice to people. There is one that shouts she gets frustrated, she doesn't understand that my family member is living in the 1930's" and "I'm full of praise for the care here. The range of nationalities of staff is great and they have been very well trained, they attend to my family members' personal needs immediately."

We observed some warm interactions between the people and staff and also heard staff talk about people in a kind and caring manner. It was clear the manager knew people well and spoke with them as they walked around the home. People's life histories in some of the care plans were informative and this type of personal history was beneficial in helping staff to get to know and understand a person better. We observed an interaction between staff and one person who was distressed and agitated. The staff member responded in an excellent way. She knew the person really well and regularly took them out for walks.

A main notice board on the ground floor gave a variety of information that people may need, such as events and activities taking place each day and photos of previous events. A copy of the latest CQC report and the complaints process and forms were also displayed. Residents and relatives meetings were held every three months and everyone including family and friends were invited. We saw the minutes of the last two meetings and saw that concerns raised had been actioned

People did not always receive the privacy, dignity and respect they should. We asked people if staff knocked on their door before entering and they said 'yes they did' but this was not our observation. On several occasions throughout the day we saw staff enter people's rooms without knocking. In the ground floor lounge staff when transferring a person from the wheelchair to a comfortable chair attempted to shield the person using a portable screen. It was evident they did not often use the screen and it took two staff to hold the screen, which only shielded the person from half of the room, with the other half of the room being behind the screen and another two staff to move the person. We saw this happen on three occasions. This did not help to ensure the person's dignity.

In the first floor lounge we heard one staff member say in a loud voice 'You going to the toilet, you wet' when a person was leaving the room. The person appeared not to notice and continued on to their room. We heard staff calling people 'love and darling' and not using their preferred name. We also observed during lunch time on the ground floor everyone was wearing a clothes protector or bib but we did not see if people were asked if they would like to wear one or not.

We also saw acts of kindness, one person liked to sit alone in the front garden and staff had put up a sun

shade for them to sit under and brought them a cup of tea. Another person who was upset was being assisted to the bathroom in a quiet and respectful manner by staff who spoke reassuringly to the person. This showed many but not all staff treated people with dignity and respected their privacy.

People were supported by staff to make decisions about their end of life care. We saw in people's care files that those people who wished to had made an advanced care plan and this had been discussed with their family if appropriate and agreed to by the person.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home and care was planned and delivered in response to their needs. When we asked people and relatives if they had been involved in the writing of their care plan we were told 'no what is it?' Although this was the response we received there was evidence in the care plans that people and relatives had been involved in their development.

We reviewed three people's care files. All the care files contained appropriate care plans that were reviewed monthly but the reviews did not always reflect the changes in people's needs. One person's care plan stated they were bedbound but it was observed on the day they were in a wheelchair. Another person had a pressure ulcer and we saw referrals to the tissue viability nurse (TVN) had been made in a timely manner after the ulcer developed. The care plan stated this person should be repositioned every three hours however on looking at the daily record this was not always recorded every three hours. There were also long gaps in the recording of wound reassessments even though the TVN had advised the wound was to be dressed every four days. There were also photos taken of the wounds but this was not done consistently, so that the progression of the wound could be monitored and action taken if needed.

There was evidence that people's nutritionals needs were assessed and reviewed monthly. People were weighed at least monthly and referred to a dietitian when they experienced a sudden weight loss or gain. However we saw records of one person who consistently had a malnutrition universal screening tool (MUST) score of two and the assessment stated they were "at high risk of malnutrition" and that they were reluctant to eat; however, they were not referred to the dietitian. Guidance for a MUST score of two states 'refer to a dietitian, set goals, improve and increase overall nutritional intake, monitor and review care plan monthly. There were no food or fluid charts on file for this person. We spoke with the manager and regional director about this person's nutritional care plan and they said they would check and take action that was appropriate for this person. They have since come back to us to say the person was on palliative care and was being carefully monitored by their GP. We had not seen this information evidenced in the person care plan on the day of the inspection

Assessments of people's tissue viability and Waterlow scores were recorded monthly and preventative action taken. The Waterlow score consists of several factors, a person's build/weight, height, visual assessment of the skin, gender/age, continence, mobility, and appetite, and any special risk factors. These results are brought together to assess a person's risk of skin damage (tissue viability).

There was a programme of activities delivered by two part time activity co-ordinators; only one activity co-ordinator was working on the day of our visit. Another activities co-ordinator had been employed and was undergoing induction at the time of the inspection. There was a programme of activities for the morning and afternoon on both the floors and some activities were held jointly for all people at the home. In the morning of our visit a pottery session was well attended by people from both floors. People were making bowls, pots and plates and painting them. People appeared to be engaged and enjoying themselves. People who remained on the first floor did not appear to be engaged in any activity.

In the afternoon we observed on the first floor that people only had pop music to listen to and no activity was provided. Later in the afternoon we saw a variety of activities had been put in front of people but people did not know what to do with these items and staff were not engaging with them to help or encourage them. We saw one person sucking on a wooden block that should have been used with rope for threading to help the persons motor skills. We spoke with the manager and regional director about the lack of staff engagement and activities on the first floor. They told us they had a dementia champion who had been working with staff to ensure people had meaningful activities and support available to them. They were confident when the additional activities co-ordinator started work this situation would be resolved.

We also observed the room was very hot and the windows were not open and the air conditioning unit had been turned off. When we visited in the morning the room was cool and comfortable on what was a very hot day. We spoke with staff and the manager about this and they said a relative had turned the air conditioning unit off as their family member was cold. The manager had spoken to the relative on other occasions about this. The manager said they could provide an extra blanket for this person if required and ensure the room was kept at a temperature to suit all people.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People and relatives told us they knew who to make a complaint to and said they felt happy to speak up when necessary. This was evidence in the records we looked at that showed the manager had dealt with recent complaints promptly and to the satisfaction of the majority of the people using the service.

Requires Improvement

Is the service well-led?

Our findings

People who lived at Lynton Hall knew who the manager and staff were by name and could freely chat with them. We observed the home manager communicating well with staff and getting involved in care throughout the day. The manager was also seen communicating with people and relatives. One person described the manager as the 'Ace of Spades, just great.'

The service was led by a manager who was in the process of registering with the CQC. The provider did not have a deputy manager in post but was recruiting to this position. In the meantime the senior nurse was taking on the role of deputy manager, along with their own nursing duties. From our discussions with the manager it was clear they had an understanding of their management role and responsibilities and the provider's legal obligations with regard to CQC including the requirements for submission of notifications of relevant events and changes.

Although the home conducted a variety of audits they had not picked up all the errors we found in medicine administration. The RN's conducted a weekly audit of the controlled medicines but we saw that these did not take place consistently. There was evidence of weekly stock checks in the medicines register on the ground floor but not on the first floor. The errors we found in stock control of medicines, errors on the MAR charts and missed medicines administration were not found. We spoke with the manager and regional director about our concerns. They recognised the errors in medicines had occurred and not been picked up by their audit processes. They said they would strengthen their audit processes to ensure these types of mistakes were not missed in the future and speak with staff about ensuring the NICE guidelines for medicines in care homes was followed.

Lynton Hall was part of the BUPA organisation and quarterly quality assurance and health and safety reviews were undertaken of the home. These included accidents and incidents, an internal inspection of the home, property maintenance, infection control and complaints. Following these reviews a management meeting was held to develop an action plan where necessary and to sign off on actions completed. The home also conducted a variety of daily, weekly and monthly audits including fire alarms and emergency lighting, water temperatures and equipment used in the home and care plans. We looked at the audits for May and June 2017 and found action had been taken where errors had been found. These checks help to keep people and staff safe and improve the quality of the service delivered.

Systems were in place to monitor and improve the quality of the service. The provider conducted surveys to gain feedback from staff, people and relatives about the quality of the service that was being delivered and to identify areas for improvement. The results of the 2017 survey for people and relatives were not available. The results of the 2017 staff survey showed positive results, with staff commenting 'I'm very happy with the management,' 'Friendly and supportive management' and 'A satisfying job that brings many rewards.'

This section is primarily information for the provider

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not have appropriate arrangements for the safe management of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure there were sufficient staff to meet people's needs in a timely manner Regulation 18 (1)