Rotherwood Healthcare (Lynhales Hall) Limited

Lynhales Hall Nursing Home

Inspection report

Lyonshall
Kington
Herefordshire
HR5 3LN

Tel: 01544340238
Website: www.rotherwood-group.co.uk

Date of inspection visit:
24 August 2017
29 August 2017

Date of publication:
18 October 2017

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 24 August 2017, with a further announced visit on the 29 August 2017.

Lynhales Hall Nursing Home is registered to provide nursing care and accommodation for a maximum of 73 older people. At the time of our inspection there were 48 people living at the home. Lynhales Hall Nursing Home is divided into two units. The 'main house' provides accommodation for up to 53 people. The 'John Sperry Unit' is a modern ground floor extension to the main building, which provides nursing care for up to 20 people living with dementia.

There was no registered manager in post at the time of our inspection. The home had been managed since our last inspection in February 2017 by a temporary manager, who was the provider's Quality Assurance Auditor. However, a new manager had just been appointed by the provider, who confirmed to us their intention to register with the Care Quality Commission (CQC). 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.

We last inspected this service on the 14 and 17 February 2017, when the service was rated as 'requires improvements in each of the domains of safe, effective, caring, responsive and well-led. We also identified four breaches of Regulations under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As part of this inspection, we looked to see what improvements had been made and how the provider had addressed the breaches of regulation.

Since our last inspection, the provider had been working closely with Local Authority and the Herefordshire Clinical Commissioning and an embargo had been imposed on new admissions at the home.

During our last inspection in February 2017, we found the provider had failed to effectively monitor the quality of services provided. During this inspection, we found that overall improvements had been made in the governance of the home. However, further improvements were still required. Staff described communication with management as poor. There was no managerial presence to quality check or have an insight into the quality or presentation of the food provided for people.

At out last inspection in February 2017, we found that people's medicines were not always managed safely. We found that overall improvements had been made by the provider. However, further improvements were still required in specific areas. Staff were able to describe how they gave people their medicines, for example by adding them to food. However, this information was not always clearly documented. Some people were prescribed medicines to be given 'when required'. Additional information was available for staff to help ensure they gave these medicines in a safe and appropriate way. However, some examples lacked sufficient detail.

The provider was unable to satisfy themselves that agency staff had the necessary skills and knowledge to effectively support people. Training and development of staff was inconsistent. Staff did not always receive the support and training they needed to meet people's individual needs.

The home was working within the within the principles of the Mental Capacity Act.

On the whole, people were supported to have the right amount of food and drink to maintain good health.

People were supported by staff who were kind and caring. People enjoyed positive working relationships with staff. Staff treated people with respect and promoted their independence. Staff actively involved people and their relatives in decisions about their care.

People received support that was individual to their needs and preferences. Staff knew people well and were quick to recognise and respond to any changes in their needs.

People received individual and group stimulation.

Most people knew how to complain and felt any concerns they had would be listened and responded to.

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.

Improvements had been made by the provider with regard to the safe management of medicines. However, further improvements were still required in specific areas.

There were systems in place to ensure that risks to people's safety and wellbeing were identified and addressed.

The provider had sufficient numbers of staff effectively deployed to ensure people were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Training and development of staff was inconsistent. Staff did not always receive the support and training they needed to meet people's individual needs.

The home was working within the within the principles of the Mental Capacity Act.

On the whole, people were supported to have the right amount of food and drink to maintain good health.

Staff supported people to access health services as required.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring. People enjoyed positive working relationships with staff.

Staff treated people with respect and promoted their independence.

Staff actively involved people and their relative in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received support that was individual to their needs and preferences.

Staff knew people well and were quick to recognise and respond to any changes in their needs.

People received individual and group stimulation.

Most knew how to complain and felt any concerns they had would be listened and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Communication between management and staff was described as poor.

People expressed concern on the reliance of agency staff.

Regular audits and checks were undertaken on the safety and quality of the care being provided.

Lynhales Hall Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection visit carried out on the 24 August 2017, with a further announced visit on the 29 August 2017. The inspection was carried out by two inspectors, a CQC pharmacist, a specialist advisor in nursing and an expert by experience. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of home being inspected. Their role is to support the inspection. The specialist advisor was a mental health nurse, who was also a Mental Capacity Act Best Interests Assessor. 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 information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority, Herefordshire Clinical Commissioning Group and Healthwatch for any information they had, which would aid our inspection. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. We received information highlighting concerns regarding the quality of care delivered at the home. We used this information to help us plan our inspection.

As part of the inspection, we spent time with people in the communal areas of the home and spoke with 16 people who used the service and 12 visiting relatives. Many of the people we spoke with were living with dementia and therefore conversations were not in-depth. We spent time observing interaction between staff and people who used the service. Some people were unable to speak to us, so we used the Short Observational Framework for Inspections (SOFI) to help us understand their experiences of the support they received. We also spoke to a visiting social health care professional, a pharmacist linked to a local GP practice and an external activities instructor.

We reviewed a range of records about people's care and how the home was managed. These included 21 care records, 12 medicine administration record (MAR) sheets, two staff files, quality assurance audits and minutes from resident and staff meetings.

As part of the inspection, we spoke with the temporary manager, the newly appointed home manager, clinical lead, three agency nurses, four members of senior staff, four members of care staff, one activities coordinator, senior administrator and the house keeper.

Requires Improvement

Is the service safe?

Our findings

Most people and their relatives told us they or their family members were safe and well cared for by staff at Lynhales Hall Nursing Home. One person told us, "I am very well thank you, and it is really not too bad here. I have settled in well and I am well looked after. I always feel quite relaxed and safe here and the staff are always there for you." Another person said, "I cannot complain about anything here. I do feel safe and I am always helped by the staff who always do their best. I have a nice bedroom and I know I am secure. If I am worried I ring the bell and someone comes straight away." A third person told us, "I am well looked after and the staff make sure I am safe and do not fall or anything."

One relative said, "Our relative has been here for 2 years now and we chose it. It is one of the best ones around here. We and the family have absolutely no concerns about their safety and security at all. We know they [relative] are safe and secure at all times. They [relative] are very unstable now and getting frail, but we have never had to be called because of a fall or injury or anything like that." Another relative told us they had no concerns about their relative's security or safety and that staff understood the need for the right balance for protection and the management of risk. A third relative believed there were staff shortages all the time and that their relative was socially isolated and not cared for. The management team at the home were aware of this person's specific concerns.

During our last inspection on 14 and 17 February 2017, we found that people's medicines were not always managed safely. Concerns had also been raised with CQC that, on some occasions, people missed doses of their medicines, because they had run out and there was a delay before staff obtained a new supply. During this inspection, we found that overall improvements had been made by the provider. However, further improvements were still required in specific areas. We looked at the arrangements for storing medicines, the medicines administration records in current use and a small sample from the previous month. A medicines policy was available to give staff guidance on safe practice. We found staff had taken action to address the issues we found at the previous inspection and had improved the process for ordering medicines.

Staff told us they had recently improved the medicines ordering system with support from their community pharmacist and a pharmacist from Herefordshire Clinical Commissioning Group (CCG), so that people's medicines did not run out. We looked at the current medicines administration records (MARs) on the John Sperry unit and in the main house. The records started on 21 August 2017, three days before our inspection, and showed that people's medicines were available for them. However, a sample of five people's MARs from the previous month showed that one person had three of their medicines unavailable for two days.

Several people had been assessed as needing to have their medicines given covertly. This meant that staff could disguise medicines in people's food or drink to ensure they would take them. Records kept with people's MARs confirmed that mental capacity assessments were in place and best interest decisions taken to protect people. Staff had recorded requesting advice from the pharmacist about the method of giving these medicines. However, there was no record of the result of this request or any action taken to follow up the query. This meant staff could not confirm they were giving medicines in a safe way.

Staff told us they intended to ask the local doctor to review the need for covert administration of medicines for several people, because they usually took their medicines without needing them to be disguised. The medicine administration records did not show whether people had been given their medicines covertly. This meant the doctor would not have complete records to carry out reviews. Staff were able to describe how they gave people their medicines, for example by adding them to food. However, this information was not always clearly documented within people's medicines administration records. This increased the risk that people might not always be given their medicines using an appropriate method.

Some people were prescribed medicines to be given 'when required'. Additional information was available for staff to help ensure they gave these medicines in a safe and appropriate way. However, some examples lacked detail; for example, one person prescribed two different medicines 'when required' had exactly the same indications for both. This could make it more difficult for staff to give the most appropriate medicine, if they did not know the person well.

Staff had recorded they had given people their medicines and recorded the reason if regular medicines were not given. Staff kept a running total of stock balances. We checked the stocks of 20 medicines. These agreed with the administration records. We saw copies of monthly audits carried out by staff for April and June. These helped staff assure themselves that people received their medicines correctly.

Some people were prescribed creams and ointments. Some were kept in people's rooms and applied by care staff. Information was available for staff describing how, and where, these preparations should be used and appropriate records kept.

Medicines were stored securely and at a safe temperature. Staff checked and recorded the temperatures of medicines store rooms and refrigerators each day to make sure they were safe for storing medicines. Suitable storage was available for medicines needing additional security. Records for these medicines were checked regularly to make sure they were looked after safely.

Most staff were able to describe confidently what action they would take if they had any concerns and showed a good understanding of the different types of abuse. We found that there were systems in place to protect people who lived at the home by ensuring appropriate referrals were made and action taken to keep people safe. The temporary manager understood their responsibilities in reporting any potential concerns in line with local safeguarding procedures. However, one member of staff told us they didn't know who they would report any concerns to, and wouldn't say anything and keep quite. We reported this matters to the management team, who took immediate action with the member of staff. This also involved ensuring all staff were aware of their responsibilities in relation to understanding and reporting safeguarding concerns.

We saw staff followed safe practice when assisting people with hoists and stand aids. They talked with the person throughout, confirmed they felt safe and secure before during and after the manoeuvre. We saw the equipment used was regularly serviced. One staff member told us about how they recognised the battery for one of the hoists was running out after a short period of time. They reported it and the provider ensured an engineer was called out and it was repaired. We saw people had individual assessments of risk associated with their personal needs. These included diet/nutrition, mobility and skin integrity. We saw one person was at risk of developing skin damage from pressure area. As a result, the risk assessment identified the equipment needed to keep this person safe from harm included recliner chair, specialised cushion and regular repositioning. We saw the identified equipment in place and saw people were regularly repositioned to keep them comfortable.

People who were at risk of falling, were being safely supported by staff to walk and move about their home.

For example, one person's risk assessment identified that they were at risk of falls. We saw them being supported by two staff members either side with a third following shortly behind with a wheelchair. We asked staff about this. One member of staff told us, "[Person's name] can become unsteady when walking. We still support them to walk to they maintain their movement, but we also have the wheel chair near as a safety measure."

We asked staff about how they reported incidents and accidents and what happens as a result. One staff member said that on discovering anyone who had been involved in an accident they would seek assistance and support them. They would complete an incident log and submit to the management team. However, some staff members felt that they did not always receive feedback following such incidents or guidance on how to reduce incidents in the future, such as falls. They were simply told to increase observations. Other staff told us that management had recognised that some people required one-on-one support, which had been provided to ensure people were safe.

On the whole, most people and relatives told us that there were enough staff available to meet their needs. One relative told us, "There always seems to be enough staff around when you need them." Another relative said, "Sometimes I have felt there was no staff around and other times it was ok. There has been a reliance on agency staff, who my relative doesn't know and which can be unsettling. Agency staff are competent and it's not their fault." A third relative told us they were aware of the use of agency staff, which they understood due to difficulties recruiting permanent staff. However this did not impact on the quality of care their relative received. One member of staff told us, "You need stable and permanent staff so that people can build up a relationship. The staff we get are regular agency and that's good. The current staffing levels are good with the needs of the residents we currently have."

Though there were some concerns about the reliance of agency staff, there was no evidence that people were not receiving support when they needed it. The agency staff we spoke with told us they were "block booked." This meant that they were allocated set patterns of work and regularly attended the home so that they got to know people and people recognised them. The temporary manager acknowledged that they were shortages of both permanent nurses and care staff, though the provider had been actively recruiting to meet the shortfall. To ensure they maintained continuity of staff for people, they had arranged with staffing agencies to block book personnel and had regular meeting with the agencies involved.

We saw that those who had been identified as requiring additional support were assisted in accordance with the recommendations. Two people had been identified as requiring one-on-one support throughout the day. We saw this occurred throughout both days of this inspection and the staff were clear about their roles to assist these people.

Staff told us and we saw that the provider followed safe recruitment processes. We saw Disclosure and Barring Service (DBS) and references were completed for new staff prior to starting work with people. A background check called a DBS check is a legal requirement and is a criminal records check on a potential employee's background.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in January 2017, we found improvements were required to ensure staff received the appropriate training and development. At this inspection, though improvements had been made, we found staff training and development remained inconsistent.

Most people told us they were supported by staff who were trained the meet their needs. However, staff we spoke with described differing experiences of their induction, training and development for their role. One member of staff said, "I should have completed several days introduction training. However, owing to circumstances this became a few hours after which point the trainer appeared to give up on me." Another staff member told us that they still didn't know if they have passed their probationary period as no update had been provided. Another member of staff said that they believed they needed more time 'shadowing' an experienced member of staff during their initial induction. They said they would have felt more confident in their role and in the training provided as a result. The provider subsequently told us that some of these comments related to a period prior to the involvement of the current management team. They believed the initial induction and shadowing process had improved.

Other staff spoke favourably about recent and relevant training associated with their role. For example, they had completed recent training on managing challenging behaviour. One staff member told us they had completed their dementia awareness training, which gave them insight into the condition and how to support people living with dementia. They said, "The key is to go with them on their journey. There is little point correcting them if they make a mistake with their thinking, but go with them. If they are upset reassure and look for the underlying thing that is upsetting them." We saw staff used these skills with people throughout this inspection, to which people responded positively.

Some staff also informed us that training regarding 'forced care,' where required in line with best interest decisions, was still lacking. Staff told us they were unsure how to support people who were resistant to care and support despite having raised this with the management team.

Staff members told us that formal one-on-one sessions with senior staff members or the management team were sporadic or non-existent. We asked the temporary manager about the support structures for staff and supervision of staff. They acknowledged this had been inconsistent due to other demands, however, with the appointment of the new home manager this was area they intended to address. Staff we spoke with understood the difficulties experienced by the provider in terms of recruitment of staff and a registered manager. As a result, they had set up their own support systems. One member of staff said, "If I need support or advice I go to my colleagues. This is informal, but seems to work for us. We don't really have anything formal in which we can discuss our work or even how we are doing as carers."

With the reliance on agency nursing and care staff, we asked the temporary manager and new home manager about the experience and training of agency staff members working at the home. They were unable to comment on the training and experience of individual agency staff members concerned. They told us that they had been informed by the agencies involved that they [the agency] were not obliged to provide

this information. We expressed the concern that the provider could therefore not satisfy itself that the agency staff deployed had the necessary skills and knowledge to effectively support people.

We saw and were told about differing experiences for people at mealtimes. One person in the main house said, "I enjoy the food most of the time occasionally it isn't to my taste, but they will always get me something else." Another person told us, "I enjoy the food and if I don't like it I can have something else." One relative told us in relation to the main house, "My relative is very happy with the food, never any complaints. They [relative] certainly hasn't lost any weight." Another relative said of the main house, "No problem with the food, they have plenty to eat and drink." A relative told us that in respect of the 'John Sperry Unit,' "I don't think there is a lot of choice and meals could better and better presented, though they [relative] gets enough to eat and drink." Prior to the inspection, another relative had complained to us about the poor standard of food in the 'John Sperry Unit.'

In the 'John Sperry Unit,' we saw people were encouraged and supported by staff to maintain a healthy diet and alternatives were offered. However, during the first day of the inspection, one visiting relative pointed out to us how unappetising the meal presented was. We saw a chicken hot pot had been served with sauce, where the sauce had curdled and did not look appealing. We spoke to the temporary manager and cook, who acknowledged this was not satisfactory, and explained it had occurred during cooking process. On the second day of our visit, we saw the alternative meal option available for people was 'ravioli.' This was served with mashed potatoes and gravy. We asked staff it this was the intended serving suggestion to which they stated they were unsure. One relative told us, "[Person's name] is a real foodie. I could not in all honesty serve them this. How do they expect them to eat it." The provider told us they were already reviewing meal service and preparation and were in discussion with an external company, who had been contracted to start at the home in the near future.

We saw people were supported by staff when they needed it. Staff plated and presented different options for people to make a decision from. For example, one staff member had two meals plated up. One was beef pie and the other the ravioli. However, both had the same vegetables and gravy and looked similar in appearance. There was little to differentiate between the dishes on which to make an informed choice. One person struggled to make a decision. After a while the staff member recommended the beef as they knew the person had enjoyed this in the past. The person smiled and we later saw them eating their meal.

In the main house, we saw a menu was clearly visible with printed in words and pictures and there was a book of menu choices with pictures for people to choose from. On the first day of the inspection, there was a good choice of meals available, which were nicely presented and served. Pureed meals was also well presented for people. Staff were very patient and did not rush people with their food.

Staff we spoke with were aware of people's individual dietary requirements and could tell us who required what and how to safely prepare the food and fluids for people to consume. When it was identified that there had been weight loss or closer monitoring of their intake was required, staff requested advice from the GP. People in both units had their weight regular monitored. Food and fluid charts were completed timely and appropriately. Where people required specialised diets such as thickened fluids or soft/pureed foods we saw this was provided.

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 to 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.

At our last inspection in January 2017, we found a number of DoLS authorisations had expired and that there had been delays in submitting reassessment applications. During this inspection, we found that improvements had been made by the provider. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The clinical lead explained the process of diarising the dates for the Deprivation of Liberty Safeguards Authorisations. They advised that the manager kept a spread sheet with all details of expiration dates, which allowed 'authorisations' to be monitored with regard to putting new assessments in a timely manner. They explained that 28 days before an 'authorisation' was due to expire, a flag was raised as a reminder that a new application must be made.

Staff asked people for their consent before supporting them. For example, prior to any supported manoeuvre staff would ask the person if they were 'ok to stand' or 'did they feel secure?' Often people were unable to provide an informed response to the question. However, we saw staff members waiting patiently until they had an indication from the person that they were happy with the task being undertaken. We saw a member of staff crouch down and establish eye contact with one person. They asked, "Would you like to go to the dining room?" After a short period of time the person smiled whilst maintaining eye contact. The staff member took this as conformation they were content with the proposal. Another member of staff told us, "We don't always get a yes or no, but we still ask and wait for a response. If we are pushed away then that is a clear no and we would return later."

We saw Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were in place on the correct forms, which indicated that people and their families (if needed) were involved in the decision. Those we saw followed current guidance.

People received regular consultation with other healthcare professionals to meet their specific health needs. One person told us, "If I need a GP, they come here, but I am quite well." Another relative said, "It is totally excellent the care here and always clean. We are involved in our relative's care plan and any changes that are made. We are informed if they had to see a GP or the nurse. We know that if a GP is required, it is organised quickly as they inform us". When unplanned weight loss was identified, guidance from the GP was sought and if necessary food supplements were provided. When it was identified that people may have swallowing difficulties Speech and Language assessments were requested and undertaken.

Good

Is the service caring?

Our findings

People received care and support that was kind and caring. One person told us, "The people who care for us are very good and very kind. I am never made to feel awkward or uncomfortable." Another person said, "I enjoy being here everyone is very kind and they really do care for me. I am very well looked after. They have to do a lot for me, but I never feel awkward or funny." One relative told us, "As I have indicated the care here is excellent, my relative is very well looked after. The staff are unfailingly helpful and kind, always friendly and ready to help. In two years we have had no problems or issues we have had to raise." One visiting external activities instructor told us they really enjoyed visiting the home and found staff really kind and caring.

We saw many spontaneous interactions between staff and people. We saw care staff interacting and supporting people with genuine care. They knew the people, their personal histories and backgrounds and the things they enjoyed. We saw staff sitting and spending time with people throughout the day. Due to electrical repair work taking place, we saw one person became upset and distressed when the lighting was temporarily switched off. Staff sat and reassured the person and took them to a well-lit part of the building where the person visible calmed down and appeared to relax. The staff explained to us that the person did not like the dark and they were not aware that the lights were going to be worked on. Had they known they would have looked to support the person in a different area where they would not have been affected.

People and relatives told us staff were very respectful of people's dignity and privacy. One relative told us, "Staff are very respectful with privacy and dignity. I see staff always knocking on doors before entering. No concerns even remotely about the place." Another relative said, "The staff are very respectful of my relative, and respect their wishes." We saw people treated with dignity. This involved choice, engaging in conversation, completing personal care in private areas and allowing people space and time to express their emotions. One person required personal care and we saw staff supporting the person to move to the bathroom. Staff were laughing and joking with the person who enjoyed their attention.

We saw people making non-complex decisions regarding food and drinks, and basic care tasks. Staff sought consent before providing any support for people such as asking whether they would like help with going to the dining room, or whether people wanted a clothes protector at mealtimes. People had plates of food presented to them for them to indicate what they would like. Staff recognised people's body language and behaviours to identify how a person was feeling. They used this knowledge to offer reassurance and support.

People received support to maintain contact with family and friends who were important to them. We saw visiting relatives were provided with the opportunity to sit down and spend time with their loved ones and were offered a tray of tea or coffee.

People were encouraged to be independent as much as they could. We saw a person independently moving freely around their home on their own or with the assistance of staff. Staff understood the importance of people retaining their independence to support their well-being. One member of staff told us, "Some people

can make some decisions, so I will try and help them decide what they want. I encourage people to be independent as much as they can, like walking, washing and dressing. I try to avoid people being confined to wheelchairs, so I encourage them to walk as much as they can to be independent."

We saw advance decisions about the care people wished to receive as the approached the end of their lives had been recorded. This included their preferred place of death and any treatments they would refuse should they not be in a position to make a decision at the time.

Good

Is the service responsive?

Our findings

Most relatives we spoke with said they believed the provider was meeting the needs of their loved one and they felt involved in determining the care they received. One relative said, "I do believe they are meeting [name] needs and they keep me informed." Another relative said, "I get invited to meetings, which review the care my relative receives. It is very helpful all of the time." A third relative told us their relative was well looked after and that staff were responsive to any needs or concerns they had. A fourth relative said, "Knowing how difficult my relative can be, they are really trying their best."

During our last inspection in January 2017, we found the provider had failed to maintain accurate, complete contemporaneous records about people's care. During this inspection, we found that improvements had been made by the provider. It was clear from the care and support plans we saw that people, and if needed their relatives and friends, were involved in the completion of their plans. These plans were individual to the person and contained information personal to them, which staff needed to know in order to care for and relate to. For example, we saw details of people's occupations, where they grew up, who mattered to them in their lives and also when things had not been too happy in their lives. Staff knew how to respond to people to reassure them and to minimise the potential for distress they may have experienced.

Care plans detailed how people preferred to be communicated with. This included clear speech, facial expressions and gestures. We saw staff using these when interacting with people. Specific medical needs were detailed in peoples care plans. For example, formally diagnosed conditions like diabetes were recorded in order for staff to provide consistent care to people. Staff we spoke with knew these specific conditions and how to support people in line with their care plan. This meant that people received consistent care and support to meet their individual needs. One visiting social health care professional told us that they believed the quality of care plan had improved as well as the completion of food and fluid charts.

Staff told us communication has improved greatly with the introduction of a communication book. This allowed for greater information sharing about people's needs amongst staff.

We were made aware that only large continence pads had been made available by the provider for people to use. Some people who would have benefited from smaller or even pull up pads were being subjected to wearing unnecessarily large uncomfortable pads. The temporary manager told us they were aware an error in ordering pads had been made by staff. They told us that in future, they would ensure orders were reviewed and were suitable for people's individual needs.

In respect of activities and stimulation for people, one relative said, "My relative does get involved in activities. Today they had done Yoga this morning. They are definitely being stimulated with something organised every afternoon." Another relative told us, "I bring our dog in regularly and everyone loves to see him and I know the Pat Dog comes regularly. There always does seem to be something going on and the carers are good with all of the residents." We saw organised activities taking place in both units with staff chatting with people, playing word games, catch and physical exercises and using stuffed toys as a means of

engagement. We saw people responding positively to these activities and engaging. We saw people engaging in group activities such as knitting. On the second day of our inspection, people from the John Sperry Unit joined others in the main house for set activities with the activity coordinator and where a cabaret singer was performing. Those who chose to remain on the unit, had enough staff available to engage and spend one-on-one time with them. We spoke to the activity coordinator, who confirmed that the provider employed a coordinator for each unit. They felt the new manager was very positive and supportive of their role and wanted to make improvements in meeting people's needs in respect of activities and stimulation.

The provider had a complaints policy and procedure in place. This provided information about how people could notify staff or management if they had concerns with any aspect of care provided. Most people and their relatives we spoke knew how to make a complaint and were confident it would be investigated by management in a timely manner. One person told us they had made a formal complaint, but no one had taken notice of them. The provider was aware of the concerns raised by this person.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us that they believed improvements had been made since our last inspection in January 2017. However, they remained concerned about the shortage of permanent staff and the reliance on agency personnel. One relative told us that a lot of good staff had left because of poor communication from management, and were concerned about lack of continuity of staff. Another relative said, "Things have improved. In the past, staff we spoke with didn't know who our relative was, but things are better. We don't leave here upset anymore as we have done in the past as things have improved."

During our last inspection in January 2017, we found the provider had failed to effectively monitor the quality of services provided. During this inspection, we found that overall improvements had been made in the governance of the home. However, further improvements were still required in specific areas. A new home manager had just been appointed, who confirmed their intention to register with CQC. The temporary manager, who was also the quality assurance lead for the provider, had been managing the home since our last inspection. They confirmed that that they would remain at Lynhales Nursing Home to provide support and guidance for the new manager. The temporary manager confirmed that the home had been working closely with the Local Authority and the Herefordshire Clinical Commissioning Group in order to make improvements. An embargo had been imposed on new admissions at the home until the required standards had been achieved.

Some staff we spoke with believed that communication within the home was currently poor. An example of this was when electrical work was being undertaken in the John Sperry Unit, no staff had been informed or that the lights would be switched off for a time. This resulted in one person who was afraid of the dark becoming distressed. One member of staff said, "Communication with management is not good and I tend to hear things on the 'grape vine.' Staff also told us that when they had passed information of concern to management regarding the actions of a relative, they had received no feedback or instruction about what to do if they should witness it again. Some staff felt they lacked confidence to raise concerns regarding working practices or risk as when they did, they received little feedback.

A number of staff felt the home had been so disjointed over the past 12 months that it was a case of "one day at a time". However, staff were positive about the future following the appointment of the new manager. They were happy that the new manager had come round and introduced themselves, and had worked several shifts alongside them to listen to their concerns. One member of staff told us, "The temporary manager has tried their best, but recruitment has been an issue. We are trying to change things, but things won't improve completely until we get permanent staff. Now we have a new manager, we have high hopes things will improve and become more settled." Another member of staff told us that the local authority embargo on new admission should not be removed until the home reached the necessary standards. A third member of staff said, "Management has been up and down, but with the new manager, they have new ideas. I feel confident in what they are going to do." A fourth member of staff told us that sometimes they had not been well-organised, but the new manager had made a difference already and listened to staff.

Having raised concerns regarding people's meal time experience, we found that there was currently no

managerial presence to quality check or have an insight into the quality or presentation of the food provided for people. Regular audits and checks were undertaken on the safety and quality of the care being provided. Effective systems had been introduced to monitor DoLS for example, however training and supervision remained inconsistent. The provider acknowledged their reliance of agency staff. However, the temporary manager told us they were considering a number of innovative ways to recruit and retain staff permanently, which remained a high priority. In the mean-time, they would continue to work closely with the agencies providing personnel.

Most staff were aware of the whistle blowing policy and told us that they would feel comfortable to whistle blow if they felt that this was needed to ensure people's safety

The provider was aware of their legal responsibility to inform the Care Quality Commission of any significant events within the service. They had submitted notifications of events when appropriate and within acceptable timescales to allow us to monitor any trends or concerns in the service.