Lyndhurst Limited

Lyndhurst Residential 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

Summary
Lyndhurst is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection, including people living with dementia. The service can support up to 20 people. The service is a domestic style property and accommodation is over three floors

People's experience of using this service and what we found
Although assurance and auditing processes were in place, they were not always effective and did not always mitigate risk to the health and welfare of people living at the service.

The service did not always identify and report accidents and incidents appropriately. Incidents were not analysed effectively meaning that people were exposed to a risk of harm.

Environmental and health and safety checks had not identified that some fire doors did not operate effectively, meaning there was a risk to people.

The appearance of the physical environment was tired in places and in need of refurbishment, including bathrooms. However, it was recognised that the service was in the process of an improvement plan.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Safe recruitment practices were in place for staff and there were enough staff to meet people's care and support needs.

People and their relatives spoke positively about the staff and care received by their loved one. One person told us, "It feels like home, the staff are lovely and know me well. I have everything I need."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was Good (published January 2019).

Why we inspected
The inspection was prompted by notification of a specific incident. Following which a person using the service sustained a serious injury. This incident is subject to an external investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of falls from

height and missing persons. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lyndhurst on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Lyndhurst Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Inspection team
The inspection was carried out by two inspectors.

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

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
Due to the risks of coronavirus, we spoke with one person who used the service about their experience of the care provided. We also spoke with three members of staff including the registered managers and senior care worker.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with three members of staff by telephone. We also spoke with two relatives to obtain feedback about the care and support received by their loved one.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• Although checks were in place to monitor health and safety in the service, the provider had failed to provide enough oversight. This meant people were at risk of avoidable harm.
• Environmental checks had not identified that several fire doors, including those situated in high risk areas such as corridors near to the laundry room and people's bedrooms, did not close to the rebate. Some doors did not have adequate smoke seals meaning that people were at risk in the event of a fire. We referred these issues to the local fire inspection service.
• Parts of the home appeared tired and in need of repair. One toilet had a cracked cistern and seat which had the potential to cause injury. In another shower room a showerhead did not fit to the wall due to a broken wall mount. Toiletries were also left on the floor. This was a potential risk to people living with dementia, through for example, ingestion.
• Communal toilets and bathrooms did not have locks. This meant that people's dignity and privacy were severely compromised.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to prevent reoccurrence of incidents. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Although a system was in place to record any incidents or accidents, the recording of the information was not effective for identifying any trends and prevent any future risk and reoccurrence.
• The recording of the specific incident was insufficient and did not include any details as to the circumstances of the incident or what injuries the person sustained.

We found evidence that people had been harmed and systems were either not in place or robust enough to prevent reoccurrence of incidents. This placed people at continued risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were managed safely and administered by staff who were trained to do so. Some protocols for people who were prescribed PRN (as and when required) medication, required further guidance for staff on how and when to give this type of medication. We discussed this with the registered managers.

Systems and processes to safeguard people from the risk of abuse
• Staff had received training in how to recognise and report on safeguarding matters.

Staffing and recruitment
• Recruitment of new staff was safe. Pre-employment checks were completed to help ensure staff members were safe to work with vulnerable people.
• There were enough numbers of staff on duty to meet people's care needs.

Preventing and controlling infection
• The service had policies and procedures in place to effectively manage the risk of infection, including coronavirus. We were assured that the provider was preventing visitors from catching and spreading infections, meeting shielding and social distancing rules and admitting people safely to the service. We were assured that the provider was using PPE effectively and safely and was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises and was making sure infection outbreaks can be effectively prevented or managed. We were also assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• Systems and processes did not always operate effectively to prevent harm to people. It was not evident that the registered managers had taken appropriate action where harm had occurred. The registered managers had not sent us a statutory notification which reflected the circumstances of the specific incident, as required by law. This meant that CQC were not alerted to the current level of risk at the service.
• During our inspection, we requested that the provider send us a notification with further details about the specific incident and a copy of the provider's own internal investigation. This was not sent until 8 days after our inspection.
• Systems in place to assess and monitor the quality and safety of the service were ineffective and had not identified the concerns found at our inspection. Oversight of systems to monitor the service did not always demonstrate safety and quality was effectively managed.
• Audits had not highlighted that the fire doors were unsafe and would not adequately protect people in the event of a fire.
• Auditing and monitoring processes had also not identified that parts of the service were unsafe and in need of repair. The clinic and laundry room were also untidy.
• Incidents had not been fully analysed to provide effective learning and so help drive forward the quality and safety of care. We noted that most incidents appeared to be unwitnessed falls during the night, there was no analysis to demonstrate that the provider had identified this and put measures in place to help prevent recurrence.

We found evidence that people had been harmed and systems were either not in place or robust enough to prevent reoccurrence of incidents. This placed people at continued risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider failed to notify CQC of circumstances of the specific incident in line with their regulatory requirements. We were made aware of the specific incident by the Local Authority. At the time of our inspection, the provider had yet to undertake their own internal investigation.
• The accident and incident form about the specific incident did not contain details of how it occurred. We

were not assured that the provider had acted on their duty of candour and shared information appropriately with us.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Minutes of resident meetings showed people's views were sought on various topics and their wishes acted upon.
• Staff told us they felt listened to and were able to provide feedback, one told us, "Managers are very approachable, I can make suggestions and they are acted on."
• People's relatives told us that the care people received was of high quality and person centred, comments included; "I am overly impressed with the level of love and care [Person] receives" and "I am very happy with the care provided, [Person] is settled and I would recommend the home."
• Relatives also old us that the home had kept them fully updated with the person's care during the lockdown period and they were able to contact the home at any time for an update.

Working in partnership with others;
• The service worked with others such as commissioners, safeguarding teams and health and other social care professionals, to ensure people received the care they needed.

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 People using the service did not always receive care and treatment that was safe. People were not always protected from harm or the risk of harm. Accidents and incidents had not been analysed to mitigate risk to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance, assurance and auditing systems were not always effective and had not identified the concerns found at our inspection. Systems and processes did not mitigate risks to people.