Care Quality Commission

Lyndhurst Rest Home Limited

Lyndhurst Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate ●

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

Summary of findings

Overall summary

This inspection took place on 22 and 27 September 2017 and was unannounced. The inspection took place in response to information of concern from a number of sources. Lyndhurst Rest Home provides accommodation and personal care for up to 44 people. There were 42 people using the service during our inspection, many of whom were living with different stages of dementia.

Lyndhurst Rest Home is a very large and extended detached property spread over three floors. It is situated on the seafront at Tankerton and has direct sea views from many of the windows. There were two lounges for people to use and two separate dining rooms where some people took their meals.

There was a registered manager in post who was present throughout the inspection. 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.

Lyndhurst Rest Home was last inspected in November 2016 when it was rated as good in every area. At this inspection we identified serious concerns which placed people's health and well-being at risk.

There had been a lack of adequate oversight by the provider and registered manager and the shortfalls in safety and quality had not been picked up until we highlighted them during our inspection. The registered manager took immediate action in response to some of our concerns but the scope of our concerns led to a large number of breaches of Regulation. We raised five safeguarding alerts with the local authority immediately following our inspection.

Risks to people's safety had not been adequately assessed, monitored and minimised. This included risks associated with medicines, hygiene, falls and eating and drinking. Staff had received safeguarding training but did not challenge poor practice that was happening in the service.

There were not consistently enough staff to meet people's needs and their deployment was not effective at times. Training in a range of subjects had been delivered to staff but understanding was lacking in some crucial areas. Recruitment processes were generally robust but required further improvement to ensure all necessary checks were made on applicants' documentation.

Risks to people's health were not always properly monitored or addressed. Mental capacity assessments sometimes conflicted with what happened in practice.

People did not all appear well-kempt and their personal care needs had not been appropriately supported. Staff did not always act to preserve people's dignity and their independence. Plans about people's end of life decisions needed to be improved to ensure people's choices and rights were observed.

Care plans were written in a person-centred way but did not always reflect practice in the service. The registered manager told us that no complaints had been received since the last inspection however some relatives said they had repeatedly raised concerns with staff.

Feedback had been sought from relatives via a questionnaire but action had not been effective in remedying concerns about people's personal presentation.

The premises were reasonably well maintained throughout and maintenance tasks had been completed promptly. Safety checks on equipment and utilities had been routinely carried out. Fire alarms were tested weekly and emergency lighting and extinguishers were checked regularly.

The district nurse, GP and other professionals visited the service to provide health checks and treatment to people.

Deprivation of Liberty Safeguards (DoLS) had been applied for and authorised when necessary.

Staff spoke directly with people with kindness and compassion. There was a range of activities available to people, delivered by designated staff. People and relatives said the registered manager was approachable and visible in the service.

We found a number of breaches of Regulation. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely or in line with best practice guidelines.

Risks had not been appropriately assessed and mitigated to ensure people's health and safety.

Staff did not demonstrate a robust understanding of safeguarding issues.

The deployment of staff was not always effective in meeting people's needs.

Recruitment processes required improvement.

Environmental and fire equipment safety checks had been regularly undertaken and the premises were reasonably well-maintained.

Is the service effective?

Inadequate

The service was not effective.

People's risks of poor nutrition and hydration had not been consistently assessed and managed.

Staff training and supervision had not always been effective in equipping staff for their roles.

The principles of the Mental Capacity Act 2005 (MCA) had not always been followed.

People had access to GPs, chiropodists, podiatrists, opticians and the district nurse.

Is the service caring?

Inadequate

Staff were well-meaning but occasionally careless around people.

People's personal care needs were not always met or supported appropriately.

People's dignity was not consistently protected.

Independence was not always encouraged or facilitated. Staffs' direct interactions with people were generally kind and courteous.

End of life care plans required greater input.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were written in a person-centred way but did not always reflect what happened in practice or people's current needs.

Concerns and complaints were not always documented or actioned in a timely way.

There was a range of activities available to people using the service with designated staff to deliver them.

Is the service well-led?

Inadequate

The service was not well-led.

There had been insufficient oversight to recognise a decline in standards of quality and safety.

Assessment and monitoring of risks to people had not been successful in a number of areas.

Auditing was very limited and did not always provide meaningful information about how the service was operating.

A poor culture had developed in which staff did not recognise or challenge inappropriate practices.

Feedback had been sought about the quality of the service, but had not always been acted upon.

Most people and staff felt the manager was approachable and the registered manager publicised an open door policy.

Care Quality Commission

Lyndhurst Rest 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. The inspection took place in response to information of concern received from a number of sources. 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 inspection took place on 22 and 27 September 2017 and was unannounced. The inspection was carried out by three inspectors over two full days.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met eighteen people who lived at Lyndhurst Rest Home. Not everyone was able to verbally share with us their experiences of life at the service. This was because of they were living with dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We inspected the environment, including communal areas and some people's bedrooms. We spoke with five relatives, six care workers; kitchen staff and the registered manager.

We pathway tracked twelve of the people living at the home. This is when we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

We received mixed feedback from people and their relatives about the service. One person told us "It's alright but it's not home. Staff are kind enough but sometimes you can't get anybody to come". Another person said "I've never lived in such a hole in all my life. Nobody listens to me and I wait around for staff to help me out". One relative said "Mum's all good-they take care of her ok; we looked around a lot of places and this was the best" and another said " Staff are really good with [Name]; I think they're alright here". A further relative commented "I worry myself sick about [Name] when I go home in case they're not being looked after properly".

Medicines were not managed safely. During the inspection we observed staff giving medicines to a person at 11am. Staff signed the medicines administration record (MAR) to show that the medicines had been administered at 8am. The actual time of administration should be recorded on the MAR if it falls more than one hour either side of the time printed on the MAR. This person was due another dose of the same medicine at 12pm but staff did not check it was safe to give two doses of the medicine so close together. This was unsafe practice.

Staff gave another person pain relief when they requested it, but did not sign the MAR immediately to show that they had done so. This created a risk that they might forget or that other staff may provide further pain relief because they could not tell from the MAR that the person had already received some. There were no signatures on the MAR to evidence that a person had received their blood thinning medicine for two consecutive doses. Although staff said they had definitely given the person this medicine there was no way to prove this by reconciling the tablets remaining with MAR records, because no stock count had been documented when the medicines were first received.

Many entries on the MAR had been handwritten by staff. When this is necessary it is best practice for two staff to check that the information about medicines and doses is correctly copied, but this had not happened. There were a number of gaps on MAR where staff had failed to sign to say that medicines had been administered. This included for items such as liquid eye drops where it was impossible to check to see whether the drops had been given after the event.

MAR were kept in a ring binder folder but all the sheets had come loose. Added to this, there were no photos of people on many of the MAR to help staff ensure they were giving medicines to the right person. This combined to increase the risk that charts could become muddled between different people and with no photos as a reference; people could receive the wrong medicines. The registered manager took photos of people and remedied the folder situation in between the first and second days of our inspection after we raised our concerns.

The medicines trolley contained two foil strips of paracetamol with no original packaging or dispensing label to show for whom they had been prescribed. Senior staff were unable to tell us who these tablets belonged to and there was a risk that they might be given to someone other than the person they were prescribed for. Some liquid medicines had not been dated on initial opening so that staff could ensure they

were disposed of within manufacturer's guidelines. Some medicines, which staff said were for a deceased person, had not been returned to the pharmacy and one of these items was in the medicines fridge. Any medicines not in use should be returned to the pharmacy to avoid the possibility of them being given to other people in error.

Open tubes of barrier creams belonging to two other people were found in the bathroom of a third person. There was a risk that other people's creams may be shared which can spread infection.

The failure to manage medicines safely and to prevent the risk of the spread of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Medicines about which there are special legal requirements had been stored and recorded appropriately. The temperature of the medicines fridge and cupboard had been measured daily and were within acceptable limits. Medicines trollies were kept locked and were secured to a wall when not in use to avoid the possibility of people or visitors being able to access medicines stored there.

Known risks to people were not always reduced in line with risk assessments. For example; one person needed to be supported to move with a hoist but we observed two staff lifting this person out of an armchair and into a wheelchair by holding them under their arms. Staff swung the person round and into the wheelchair while the person had their legs tucked up beneath them. This was unsafe practice and placed the person at risk of falling or being injured by staff handling them in this way. Staff told us they knew it was wrong to move the person like this but that the podiatrist was waiting to see the person and they felt rushed. They also said that the person could weight bear sometimes, but the registered manager confirmed that this person should only be supported to move with the hoist. Following the inspection the registered manager told us that the staff involved would receive refresher moving and handling training as a priority.

Most people had individual emergency evacuation plans (PEEP) in place but we found that these were not available for two people we checked. In other cases, the PEEP had not been updated to show important changes to people's mobility. For example, one person's PEEP stated they were independently mobile but staff and the registered manager told us the person could no longer mobilise alone. There was a risk that people would not receive the appropriate support in case of an emergency evacuation because staff may believe people to be more independent than they actually were. The registered manager said they would update these PEEPs as a priority.

Incidents and accidents were not effectively managed. One person had a recent fall in the garden when they sustained a cut to the head and received emergency treatment from ambulance staff. During our inspection we observed the person in the garden; they were trying to climb up onto a bench. Initially they were unaccompanied; however, a member of staff did eventually intervene before the person was able to stand on the bench and remained with the person supervising them. Although staff had completed a record of the accident, there had been no review of their mobility risk assessment, referral to the falls clinic or any other measures put in place to reduce the risk of further occurrences. We discussed this with the registered manager who acknowledged no risk assessment review or other action had taken place.

The failure to minimise known risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service was not hygienic in some areas. Used latex gloves were seen in open bins and on the floor in parts of the service. There were dried faeces on one person's bed frame and urine residue left in a very stained and encrusted commode pan in another person's bedroom, making the room odourous. There was

an extremely bad smell in the main lounge on the first day of our inspection. It was so strong that inspectors had difficulty remaining in the room for any period of time, but some people who were not independently mobile sat there all day and had their meals served there. The registered manager was aware of the smell but told us it "Comes up from time to time". However, it was unacceptable for people to be spending much of their time in such an unpleasant atmosphere. One relative told us "That awful smell's always there" and another said "The home is generally clean but there is a very strong smell of urine most of the time". Two further relatives said they had no concerns about cleanliness in the service. The carpet in the main lounge was deep cleaned several times between the first and second days of our inspection. Although an immediate improvement was noticed on the second day, the smell began to appear again as the day wore on.

Premises and equipment were not suitably clean, which is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Communal and en-suite bathrooms and toilets were clean and sanitary. Staff wore latex gloves when delivering people's personal care and there was a plentiful supply of gloves and aprons available.

Staff were able to tell us how to recognise abuse or neglect, but some of the practices happening in the service did not protect people and had not been reported or challenged by staff. For example, we observed a number of incidences of poor moving and handling practice during the inspection, some people appeared unkempt with long and dirty nails, some people did not receive the support they needed to eat and drink and people were not protected from possible over or under dosing of their medicines.

In March 2017 a member of staff alleged that another staff member had physically assaulted a person living at Lyndhurst Rest Home. The allegation was very serious but the incident was not raised with the registered manager until two days after it was said to have happened. The police and local authority were notified by the provider and the staff member was immediately suspended then dismissed. Following receipt of the allegation, the registered manager asked other staff if they had any concerns about the dismissed staff. Some staff came forward to say that they had witnessed inappropriate verbal and/or physical actions taken by them. However, none of the staff had reported these concerns until they were asked by the registered manager. This showed a lack of understanding of staff responsibilities to raise the alarm if abuse or neglect was suspected. The provider produced updated safeguarding policies and arranged refresher training for staff after the incident in March 2017, but our findings during the inspection showed that staff continued to have a poor understanding of protecting people.

The failure to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The deployment of staff was not efficient and led to people's needs going unmet in some cases. We observed the whole of the lunch period in the lounge and dining room on the first day of our inspection and saw that some people in the lounge waited for their meals for half an hour after others had received theirs. Some people had to wait while others sitting either side of them had their lunch. Meals were served one by one and three people clearly needed support to eat but received very little assistance or encouragement. Staff who were assisting people kept getting up to attend other people or tasks which interrupted people's meals. Other staff were observed standing around in the dining rooms where people generally required less support than those seated in the lounge. We raised our concerns about this with the registered manager and on the second day of our inspection people did receive more support, but again staff left people to do other tasks and some waited a long time to receive their meals.

Most people lived with dementia and some people had an advanced stage of the condition, meaning they needed support with most aspects of their care. Some people needed support with meals, two people required a hoist to support them to move and others needed staff support to walk. The premises are very large and set over three floors, with two separate lounges and dining rooms. Many people were unable to use call bells so the registered manager told us that hourly checks were made on people during the night. Recording sheets showed that this did happen most of the time. However, we noticed that on two occasions when people had fallen in the early morning, they had not received checks for almost two and four hours respectively prior to falling. Night staff had not been deployed in such a way that they ensured people received hourly checks throughout.

Although the registered manager told us that there should generally be a staff member in the main lounge at all times, there were a number of occasions during the inspection when people were left alone. One person was seen leaning right out of their chair to reach something on the floor but there were no staff around to see this and intervene. A relative told us "It worries me when staff are not in the day room. I have helped residents in the day room myself at times".

The registered manager told us there were six care staff on shift in the mornings and five in the afternoons with three wake staff overnight for 42 people. This meant that staff had to complete personal care tasks and provide breakfast to seven people each in the mornings when fully staffed. However rotas showed that shifts were short staffed on five occasions in the four weeks before our inspection. On one morning there were only four care staff on duty; meaning they would each need to support 10 to 11 people. A relative told us "Some days staff are rushed off their feet" and there were times when extra staff were needed. The registered manager did not use a dependency tool to calculate the number of staff required based on need and the layout of the premises. They told us that they made daily assessments of people's care needs and any changes, and rostered staff based on this information. There were no records to support these daily needs assessments however.

The failure to deploy sufficient staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Recruitment processes were generally robust, with all the necessary checks and documentation having been sought for new employees, including criminal records checks, references and identity information. However, the previous employment details on one staff's application form did not match those on their CV. There was no evidence that this had been queried with the staff member and this is an area for improvement so that the provider can be sure that only suitable staff are employed to work with people.

The premises were in a reasonable decorative state overall, and en-suite bathrooms were especially well equipped, bright and spacious. Maintenance records showed that any repairs had been carried out in a timely way. Safety checks on gas, electrical and water supplies had been regularly conducted by professional contractors and hoisting equipment and the passenger lift had been routinely serviced.

The fire alarm had been tested weekly and there were records of fire drills to document how efficiently the service could be evacuated. Emergency lighting and fire extinguishers were checked on a rolling programme to ensure they remained fit for use. A fire risk assessment had been carried out in 2011 by a professionally qualified person. Annual reviews had been carried out by the registered manager who had received guidance to be able to do so effectively. Following our inspection the provider told us they were arranging for a full safety review to happen in the service.

Inadequate

Is the service effective?

Our findings

People were not adequately protected from the risks of poor nutrition and hydration.
On the first day of our inspection, we observed the entire lunch period in the main lounge. At least three people seated there did not receive sufficient or timely support to eat and had very little of their meals. We checked weight records for these people and found that all three had lost considerable weight. These people were living with advanced dementia. One of them looked bewildered at their meal which was placed in front of them without explanation. The registered manager said this person usually ate well and preferred to use a spoon, but none was provided with their lunch. Although staff cut up the meal, they then walked away and left them to manage alone. The person did not eat at all until a relative visited and assisted them.

We spoke with the registered manager about their monitoring processes and trigger points to refer people to nutritionists or dieticians when weight loss was identified. The registered manager explained this would take place if people lost 3Kg or more. This person's care plan contained a letter from their GP dated 1 February 2017. It advised 'There is evidence of consistent weight loss' and stated '(Registered manager's name) will be monitoring more closely and seeking appropriate support'. We saw the person had been weighed regularly once a month from October 2016 until September 2017 and in total they had lost 11.3Kg. We saw a record of food eaten had been started for the person on 25 September 2017 after inspectors raised concerns about the person's poor intake. We asked the registered manager what other action they had taken and what support had been requested in relation to person's weight loss. In spite of the letter from the GP and person's weight loss significantly exceeding the 3Kg trigger point, the registered manager acknowledged no other action had been taken until our inspection.

Another person's care plan said their food needed to be cut up small, but their food was cut into large pieces and they only received support from staff after 25 minutes; when their meal was completely cold. They ate very little lunch and they had lost 5.2kgs since June. The registered manager said that this was because the person had been unwell. Their care plan also highlighted that they needed drinks in a spouted beaker and to be prompted to drink them. At lunch the person was served a drink in an open cup and was assisted by staff to take only two sips of their drink. The registered manager told us that this person no longer needed a spouted beaker but their care plan had not been updated to show this change. There was no food or fluid chart in place for this person so that their intake could be monitored and professional advice sought if necessary. This person was referred for dietetic advice after inspectors raised concerns about the weight loss and lack of intake observed.

People received their pudding at the same time as their main course. One person was seen to pour their semolina over their lunch, but no replacement meal was brought for them and they ate very little. One member of staff was trying to support this person and another person to eat at the same time and kept moving between them. This did not give them time to properly encourage people to eat and drink and was disruptive to people. This person had lost 6.3kgs since January this year and had been referred to a dietician who prescribed supplement drinks. There was a food recording chart in place for this person, but it had not been completed consistently. For example on the first day of our inspection at 3:45pm, no entries had been made on the chart for this person. The registered manager said that staff completed the charts later in the

day, but this practice provided an opportunity for inaccurate information to be recorded because staff would be unlikely to be able to remember exactly what and how much people had eaten for breakfast for example. In two of the weeks prior to our inspection, this person's intake had only been documented on one or two days, although MAR showed they had been receiving their meal supplement regularly. There was insufficient information for the registered manager to determine whether people at known risk from poor intake were receiving adequate nutrition and hydration. On the second day of our inspection, activities staff supported some people to eat their lunch, but others still waited for 20 minutes to be served their meals.

Malnutrition has a wide-ranging impact on people's health and wellbeing. Screening for the risk of malnutrition is important for enabling early and effective interventions. Established care sector monitoring tools, such as the Malnutrition Universal Screening Tool (MUST) were not used and because of a lack of information, staff were unable to correlate people's weight to BMI scores to identify if people were at risk. Where weight loss was evident, people continued to be check weighed at the same intervals as people who had not lost weight. Discussion with the registered manager and staff found a lack of importance attached to the significance of weight loss.

Other people had been assessed by Speech and Language Therapy (SaLT) due to swallowing difficulties. One person had been advised to drink thickened fluids from an open cup and eat a mashed diet. We observed this person eating bacon and half slices of toast and drinking from a spouted beaker. The registered manager told us that this person had capacity to make their own decisions and could therefore eat and drink what they wished. The care plan for this person however stated that they had been assessed on 21/9/17 as lacking capacity to participate in planning their care or assessing risks. The registered manager said that the person's capacity varied but in any event there was no guidance for staff about the risk to this person of choking if they chose to ignore professional advice from SaLT.

The failure to mitigate risks to people in relation to hydration and nutrition is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us "The food looks very good and plentiful and staff have learnt what [Name] likes" while another commented "The food is OK, nothing spectacular just adequate".

Risks to people's health had not always been appropriately assessed or mitigated. Some people had been assessed as at risk from pressure wounds or skin breakdowns and had special air mattresses in place. These mattresses should be set to the weight of the person using them to achieve the intended pressure relief. However, we found that mattresses and pressure cushions were set at the wrong levels throughout the service. For example; one person's mattress was set to 120kgs when they weighed 64.1kgs and another person's air cushion was set to 31kgs when they weighed 53.3kgs. Staff said that people sometimes "Fiddled" with the settings but most of the air pumps we checked were tucked away at the ends of beds or behind armchairs. The registered manager said that the pressure relieving equipment should be checked daily by staff, but there were no records or evidence to show this had been done.

There was no proper care plan for a person with epilepsy, to detail how staff should support them during and after a seizure. This person had experienced recent epileptic seizures but the only information available to staff was to call an ambulance if a seizure lasted longer than five minutes. Staff had not received training about epilepsy which placed the person at risk of receiving inappropriate care and treatment.

People's health risks had not been appropriately assessed and minimised which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had conditions such as diabetes, health care plans provided guidance about high and low blood sugar level (BSL) readings and what to do in these circumstances. However, people who experience diabetes can also be susceptible to circulation problems in their feet and lower limbs. Diabetes can also place people at greater risk of serious eye problems, such as cataracts, glaucoma, and retinopathy (a disease of the retina). Although arrangements were in place for foot and eye care to take place, it was not clearly recorded and linked to diabetic care. Recording of this day to day care would help to ensure any changes in condition were noted and acted upon. This is an area we have identified as requiring improvement.

Some people had skin wounds or pressure areas. The district nurse visited regularly to assess and dress people's wounds. People's dressings appeared clean and some people had special inflatable boots on to help protect their skin. A relative told us "[Name] gets regular visits from the district nurse and GP because they have pressure sores". The GP responded to requests from the service to visit people when there were concerns about their health. Visits from the podiatrist and chiropodist happened regularly and there was evidence that people had seen opticians.

Staff had received a range of training in mandatory and other subjects. However, this training was not always effective in practice. For example; although staff had received training about medicines, they did not follow this during the inspection when MAR were not signed off immediately following administration. All staff had received training about how to support people to move safely but methods used during the inspection were unsafe and placed people at risk. For example, two staff physically lifted a person from their chair rather than using a hoist, other staff transferred a person into a wheelchair which had not had the brakes applied and kitchen staff were observed pulling a person along by their arms rather than walking alongside the person at their own pace.

Two seniors and four care staff had not received up to date training about managing behaviours that challenge. During the inspection we witnessed a person becoming physically aggressive towards a senior staff member. This staff member had received recent training about challenging behaviours but did not manage the situation competently; and the registered manager had to intervene. In addition, around 12 care staff including some seniors had not had updates to training about dementia. Given that many of the people using the service were living with this condition it was important that knowledge should be regularly refreshed. Some staff showed poor understanding of dementia. One staff offered a person a child's jigsaw to complete. The person became offended by this and said "That makes me feel like an idiot" and staff responded "I just thought it would be easier for you". Although well-intentioned, staff had not appreciated that living with dementia was not the same as being a child. Another staff member cut up a person's food without asking them first and the person told us "I don't need them to do that". One relative told us "The staff are nice enough; they just don't have the training to look after people properly".

Staff had received regular supervision sessions with the registered manager. However, these had failed to identify the training and competency needs we highlighted during the inspection, so were of limited effectiveness.

The lack of effective training and supervision is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an induction programme in place for new staff, which included shadowing more experienced staff.

All staff had received training about the Mental Capacity Act (MCA) 2005, which is to protect people who lack

mental capacity, and maximise their ability to make decisions or participate in decision-making. In practice staff were sometimes observed seeking people's consent for straightforward decisions and providing people with choices, but this was not always the case. For example; at lunch time staff told people "You're having your lunch in here" without offering any choice. Some staff asked people's permission before placing food protectors on them, while other staff did not. One staff was observed to ask about a person's lunch "Would you like me to cut it up for you?", but other staff cut up people's food without asking if this was what they would like.

Similarly, some formal assessments of capacity did not always agree with what happened in practice; for example we were told by staff that a person who had been formally assessed as lacking capacity to make decisions about any aspect of their care had "Chosen not to follow advice from SaLT". This confused picture around people's capacity gave rise to the risk that people's rights and choices may not always be observed and is an area for improvement.

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had received DoLS authorisations for five people and had made other applications which were being considered by the relevant authority. The registered manager had notified the CQC when authorisations were received.

There were few adaptations to the service to make it suitable for people living with dementia. There was no picture signage around the premises to help people orientate themselves to communal areas, and individual bedroom doors did not all have a name or picture on them to make them easily identifiable. There were no picture menus in use so that people could see an example of what they chose for their meals, and a pictorial menu board in the corridor was blank throughout the inspection. White boards in the dining rooms had activities and lunch choices written on them, but these dated back to 18/9/17. This was not helpful in supporting people living with dementia or memory loss and is an area for improvement.

Inadequate

Is the service caring?

Our findings

We received mixed feedback from people and relatives about whether the service was caring. One person told us "They're lovely girls [Staff] and they do their best for me". A relative told us "Staff say they will do things and then they don't do them" and another said "I've never seen staff be 'Offish' with residents, but some staff interact more with people than others", "By and large they're pleasant and kind".

Staff appeared well-intentioned but were sometimes careless when supporting people. For example; we observed two occasions when staff moved people's side tables without explaining what they were going to do. In the process they hit people's legs with the tables and caused them to cry out. One of these people already had sore legs which had been dressed by the district nurse.

Some people did not appear well-kempt and several people had long and dirty finger nails. Three relatives raised concerns with us about this. One said "[Name] often has dirty nails and personal hygiene is not good". Another told us "[Name's] nails could be cleaner and cut more regularly". One person was observed eating with their fingers and placing dirty nails into their mouth, which can cause the spread of infection. Long nails also present a risk that people will catch their own or others' frail skin on them and cause tears or sores to develop. Although some people's care plans recorded that they could be resistant to personal care there was no evidence that advice had been sought about this from other professionals, for example the community mental health team. The registered manager told us that activities staff cleaned and cut people's nails and provided hand massages. This had not prevented some people having very long, sharp and dirty nails during the inspection.

Bath and shower records indicated that people had sometimes not had them for periods of between two weeks and up to a month in one case. At other times, bathing and showering was documented as more frequent; such as weekly. The registered manager told us that this was a recording issue and that people had more baths and showers than was shown on charts and on a planner. However, some people did not appear fresh or well-kempt and had dirty nails, which indicated they had not received consistently adequate support with their personal care. One relative told us "People don't get enough baths here and their clothes are often not changed" and another said "[Name] is often wearing dirty clothing when I visit". A different person was wearing dirty and stained trousers on both days of the inspection. Their care plan documented that they needed staff assistance with all grooming and dressing because they were unable to support themself with these tasks. Staff support had not been sufficient to preserve this person's dignity by ensuring they remained well-presented.

When staff spoke directly with people during the inspection, they did so with kindness and compassion but were also heard shouting to other staff across the lounge and over people's heads at times. For example; "Has she been changed this morning?" and "Where am I putting [person's name]"? This was disrespectful of people's privacy and was not dignified for them. One relative told us "Staff can sometimes seem brusque with people but I have to defer to staff's professional judgement because I don't know a lot about dementia". Another relative said that staff were "Very good and very approachable".

On the first day of our inspection, people with more advanced dementia were seated in the main lounge for most of the day and had their meals there. The smell in this room was extremely unpleasant; and overpowering at times. It was not caring to leave people in this atmosphere and environment for long periods and especially to take their meals. The registered manager said they were aware of the odour but that it was not always so bad. They did arrange deep-cleans between the first and second day of our inspection, but the issue should have been dealt with sooner.

The failure to protect people's dignity and treat them with respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff called people by their preferred names and ensured that Inspectors were made aware of these so that no offence was caused to anyone. They knocked on bedroom doors before entering and covered people's bare legs if they became exposed. Some staff asked people if they would like to wear a food protector while other staff placed these on people without asking.

People were not consistently encouraged to be as independent as possible. For example, some people's care plans stated that they needed the support of a Zimmer frame in order to mobilise. However, these people did not have Zimmer frames to hand so could not move independently. Another person did have their walking aid with them but this was removed because staff said it needed a repair. The aid was not replaced with another and we witnessed the person struggling to walk without it. One relative told us they had seen staff actively encouraging their loved one to walk rather than use a wheelchair while another said that their relative did not receive sufficient support to assist them in walking independently.

A further person's care plan recorded that they needed a plate guard; which is a plastic rim which fits onto a plate and helps prevent food being pushed off the sides. Plate guards can help people to retain independence when eating by enabling them to keep food contained within the plate while they eat. The plate guard was positioned incorrectly on this person's lunch plate which meant food continued to be pushed off and onto the table. Staff did not appear to notice this or put it right. Although staff were busy at lunchtime, they did not pick up that some people were not receiving enough support and just left meals with people who were unable to help themselves. The registered manager said that three people we identified usually managed their meals well; but we saw in their records they had all lost weight which would indicate they had not been eating enough.

The failure to promote independence and appropriately meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were generally well-meaning but their actions sometimes created risks or did not take account of people's right to make choices. For example, staff were quick to provide pain relief for a person who asked for it, but they did not sign the MAR to show the medicine had been given so that other staff would know that another dose should not be provided for at least four hours.
There was little evidence that people or their relatives had been involved in care planning which led to some aspects of people's care being delivered in a task-orientated way. For example; staff cut up people's food without checking this was what the person wanted and beakers of drink were already placed on tables when people took lunch in the dining rooms; so no choice had been offered about what people would prefer.

There was nobody receiving end of life care during our inspection. There was some information in some people's care files about funeral arrangements but the specific end of life care plans we reviewed had not been completed to record people's wishes for their final days. Four staff including the registered manager had received training about palliative care but training about loss and bereavement had not been delivered

or refreshed in line with the provider's own requirements. This is an area for improvement.

We observed some kind and caring interactions between staff and people during the inspection. For example; one person was upset and repeatedly asking to go home. Staff gave the person a hug and said "It's ok [person's name], I'm here with you; please don't upset yourself darling- let's go and find you a cuppa". Staff's affectionate approach distracted the person who happily went off with staff. Another person was feeling a little poorly and staff said "I know you've got a bit of a cold darling, but you must keep drinking". Other staff laughed and joked with some people and used appropriate touch to offer reassurance or comfort.

Activities staff supported some people to eat their meals on the second day of our inspection. They maintained eye contact with people, offered encouragement and described the meal to them, while also making 'small talk' and actively trying to engage people. Those people who were supported by activity staff ate well and visibly enjoyed the interaction.

Requires Improvement

Is the service responsive?

Our findings

Care files contained detailed information about people's lives before they moved to Lyndhurst Rest Home, and care plans were written in a person-centred way. However, there were numerous examples throughout the inspection of when the practice in the service differed to what had been written about people's needs and wishes.

One person had a care plan relating to a medical condition which required staff to take specific action to protect a wound site. We observed this person with the wound visible and uncovered even though the care plan said it should be dressed. Another person's care plan said that they could mobilise with their walker and the assistance of one staff member 'at all times'. We observed this person walking without their aid and no staff support on several occasions. The person was unstable on their feet and propped themselves against the wall for support or held the arm of another person using the service. Inspectors asked staff if this person needed staff to assist them mobilise and they replied that "They sometimes do get up and walk on their own". This did not agree with the care plan directions and meant that there was a risk that people would not receive appropriate care and treatment because of confusion between documented needs and staff practice.

Professional advice had been received about one person's communication difficulties and their care file held a letter stating that pictures and communication cards should be used to assist them. During the inspection this person became frustrated and upset because they could not make staff understand what they wanted, and it transpired that they urgently needed the toilet. We asked the registered manager if this person had any communication cards to use and they said that "There's a book somewhere but I couldn't tell you where at the minute". Other staff were also unable to direct us to any cards or pictorial aids to support this person to communicate. The lack of person-centred care for this person resulted in them becoming aggressive towards staff and not having their needs met promptly.

The failure to provide person-centred care, designed to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Most people's bedrooms had been personalised in some way with photos or people's own possessions. Preferences for male or female care staff had been documented along with the times people liked to get up and go to bed and their preferences in relation to food and drinks.

The provider's complaint's policy was on display in the entrance hall of the service. This stated that all complaints 'However trivial' would be investigated. The complaints policy set out how the staff should log a complaint together with various acknowledgement and response timeframes. We were told the service had not received any complaints since our last inspection. However, some of the relatives we spoke with said that they had raised concerns on a number of occasions with staff about aspects of their loved ones' care, but that these had not been addressed promptly. One relative said "I've never seen staff take a note of any issues I've raised and it can take a long time for things to be resolved".

Staff told us any concerns were recorded in care plans and dealt with before a complaint arose. However, no other records were kept of the concerns raised which did not allow effective oversight into areas which may impact on other people, or support quality assurance process to provide insight into areas that had caused concern.

The lack of a robust complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On the first day of our inspection there were limited organised activities for people because the activity manager was on leave. Some people were doing jigsaws, but we noticed these were intended for young children. The registered manager did show us a very large jigsaw designed for adults which they said some people were completing between them. Another person had two building bricks on their table and some people read magazines, played cards together or watched TV. There was a seated exercise activity in the afternoon but one relative told us "They only do that for the residents who aren't so bad with the dementia. There's nothing for the others". On the second day of our inspection however, the activity manager was back at work and a number of lively sessions were enjoyed by people. Old time songs were played for example, and many people were up and dancing in a happy and relaxed atmosphere.

The activity manager planned and oversaw activities at each of the four services owned by the provider. They visited Lyndhurst Rest Home regularly; providing guidance and support for the two activity coordinators employed at the service. Activities staff had spent time with people and their relatives to understand about people's life histories and produced folders with pictures and photographs to help to get to know people and provide opportunities to reminisce. Activity sessions within the service included bingo, singing, dancing, puzzles, reminiscence boxes and exercise to aid coordination. Some people made necklaces and bracelets or enjoyed handling sensory materials with different textures and sounds.

Musicians and singers visited the service and some people visited Age Concern groups. Regular coffee mornings took place where relatives were welcomed and plans were underway for a Christmas party. We were told arrangements were in place for a therapy dog to visit the service, which people were excited about. Staff were mindful of people who were unable or preferred not to attend communal activities and ensured they spent time with them, for example, reading to people. Staff recorded activities people received and were devising evaluation forms to ensure activities provided were suitable and meaningful for the people who received them.

Inadequate

Is the service well-led?

Our findings

At our last inspection, Lyndhurst Rest Home had been rated as good in every area. At this inspection however, we found that the quality and safety of the service had significantly deteriorated throughout; resulting in a large number of breaches of Regulation and the service being placed into special measures.

There had been a lack of oversight by both the provider and registered manager which meant that they had failed to pick up on the decline in standards of the care people experienced. Auditing had been very limited, and was insufficiently detailed to provide meaningful information about how the service was operating and performing. The provider did not carry out any structured checks of their own, although we were told that this was being planned at the time of the inspection. The registered manager had not conducted audits to gain an overview of weight losses, falls, bathing and people's fluid and food intake for example. This caused a number of concerning issues to go undetected and unaddressed until they were highlighted by our inspection. The registered manager did however take immediate action when we drew their attention to some issues, for example the bad smell in the main lounge, the poor state of the MAR folder and making referrals for dietician input for some people.

There was no overview of weight losses, with each person's weight being documented in their care plan or a weights book. We asked the registered manager to prepare a list of all those people losing weight; between day one and two of our inspection, but when we reviewed this, it did not include some people we had already identified as having lost weight. An audit of weights would have allowed the provider and registered manager to monitor them and have a single document highlighting losses and gains. This lack of auditing had led to some significant losses not being referred for professional intervention, and people remaining at risk of poor nutritional intake.

No checks had been made by the registered manager of people's food and fluid charts to ensure staff were completing them consistently and that people were receiving adequate nutrition and hydration. Neither had there been any management review of bathing and showering records to see that these were accurate and that people were being properly supported with their personal care. Had these checks been carried out, they would have alerted the provider and registered manager to the long gaps between bathing records in some cases.

Falls had not been audited so that a clear picture could be gained of where and when people had fallen. Our review of falls showed that the majority of these happened during the night shifts. This data could have been used by the provider and registered manager to assess the levels and effectiveness of night staff, and consider measures such as specialist alarm equipment to help prevent further falls.

Health and safety and medicines audits had however been completed, but were not effective in drawing attention to the shortfalls found during the inspection. For example, air mattresses and cushions were shown to have had pressure checks daily as at 15/8/17 but none of the pumps were correctly set during the inspection. Walking frames were noted as being 'All in good order' but staff told us that one person's frame had had a screw missing from it "For ages" and the walker was taken away from them during the inspection.

Medicines audits had been carried out monthly but no issues had been found since January 2017. This was at odds with our inspection findings which showed considerable concerns in this area, placing people at risk to their safety and well-being.

The failure to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Auditing of medicines for which there a specific legal requirements had been regularly and effectively carried out. We found no concerns in this area during the inspection.

Known risks to people had not been properly mitigated, for example for a person with epilepsy. There was no detailed care plan guidance for staff and they had not received training about the condition. Updates to PEEPs had not been made for some people, and their reduced mobility had not been documented or taken into account in assessing how they would be evacuated in an emergency. Staff had received training about moving and handling and supervision from the registered manager but this had not prevented them from performing unsafe manoeuvres in front of Inspectors, without seemingly appreciating the dangers to people. Although risks to people had been identified, actions to reduce them had been insufficient.

The failure to assess, monitor and mitigate risks is a breach of Regulation 17 (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The staff team were friendly and approachable to people, but unsafe and inappropriate practices had been allowed to develop in the service, which was indicative of a poor culture. For example; staff were heard calling out to each other across lounges and dining rooms in a way which was not respectful of people's dignity. Although staff had received training about safeguarding, they showed a lack of understanding about protecting people in practice. This was demonstrated by the unsafe way in which medicines were managed, the inappropriate ways in which people were supported to transfer or mobilise, and the lack of adequate personal care or nutritional support delivered to some people.

Some staff had not come forward to report issues about another care worker's inappropriate behaviour towards people until they were asked about this after an incident. The provider had taken swift and appropriate action once they were made aware of the matter and had updated their safeguarding policy and provided refresher training to staff following the concerns. This had not been sufficient however to ensure staff fully appreciated the types of treatment which could be deemed to be abusive or neglectful; and their responsibility to take action if they became aware of it happening.

Registered persons are obliged to inform the CQC about certain events or incidents by way of statutory notifications. The registered manager had not submitted statutory notifications about two safeguarding issues. This meant that the CQC could not maintain an informed overview of events and incidents happening in the service. The registered manager had however raised safeguarding alerts with the local authority on each occasion.

The failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had introduced a staff member of the month award to encourage staff to perform to their best. Staff we spoke to said this made them feel valued and recognised by the registered manager.

Feedback had been sought from people and their relatives by way of meetings and a questionnaire. At these

meetings the registered manager had explained that they had an open door policy and welcomed any suggestions or concerns. Staff meeting minutes showed that staff had been given the opportunity to raise any suggestions or issues.

Following the inspection we were sent analysis of the most recent questionnaire which had been responded to by around 50% of relatives. The results of this showed that the majority of relatives were either satisfied or very satisfied with most aspects of the care provided. However, around 13% of those who responded to the questionnaire were not satisfied with the hygiene, grooming and personal presentation of their relative. This issue had not been adequately actioned at the time of our inspection and is therefore an area for improvement.

The registered manager was qualified to NVQ level five and had also achieved a Registered Manager's Award (RMA). They told us that they kept abreast of developments in the social care field through local care home forums and the internet. They said that they undertook training sessions alongside staff to ensure they knew the content of courses. Most relatives and people we spoke with felt the registered manager was approachable and staff said they provided good leadership.

Links with the community had been fostered through visits from church ministers and a local choir which regularly came to sing for people.