HC-One Limited

Lyndon Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 07 June 2018 and was unannounced. At the last inspection of the service in May 2017, the provider was rated as Requires Improvement in all five key questions. At this inspection, we found that while some regulations had now been met, there continued to be concerns in all areas and further breaches of regulation were identified.

Lyndon Hall 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. Lyndon Hall is registered to provide care, nursing and accommodation to a maximum of 80 older people, some with a diagnosis of Dementia. At the time of the inspection, there were 77 people living at the home.
There was no registered manager in post, but a new manager had been recruited and they were planning to apply to become registered. 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.

Administration and recording of medicines given was not always done safely. Medicines were not always stored at the correct temperature required to keep the medicine at it's optimum potency. Staff were not always available to keep people from harm. Staff understood the procedures they should follow if they witnessed or suspected that a person was being abused or harmed. Accidents and incidents were responded to appropriately.

Staff did not always have the skills and knowledge required to support people effectively. Staff did not always have a clear understanding of the Mental Capacity Act and how best to support people in line with it's principals. People did not always like the food provided and staff were not always supportive when people required assistance to eat. Staff gained people's consent before assisting or supporting them. Staff received an induction prior to them working for the service and could access ongoing training to assist them in their role. Staff could access supervision and felt able to ask for assistance from management should they need it. Staff supported people's healthcare needs.

Staff were not always caring towards people and their dignity was not consistently maintained. People were encouraged to retain an appropriate level of independence and choices were given to people were it was appropriate.

Care plans were in place, but it was not always clear if people had been included in compiling them and they were not always detailed. People were not consistently offered a stimulating environment. People's preferences for how they wished to receive support were known and considered by the care staff. People knew how to raise complaints.

There had been a lack of consistency in management and some people remained unsure of the management status of the home. There was a high turnover of staff, which had had a negative effect on some people. The environment was not always conducive to people's wellbeing. Meetings were held where people were able to contribute. Quality assurance audits were carried out, but these did not identify concerns in all areas. We did not always receive notifications as required.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always consistently safe.

Medicines were not always given, stored or recorded appropriately.

Staff were not always readily available to people.

Risk assessments were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always know how best to support people.

Food and drink was not always to people's liking and they were not consistently supported appropriately to eat and drink.

Staff knew to gain people's consent before assisting or supporting them.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt that not all staff were kind and caring towards them.

Staff did not always maintain people's dignity and provided respectful care.

People were involved in making decisions about their care and were given choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always provided with a stimulating environment.

Staff considered people's preferences when carrying out care.

People knew how to raise complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staffing levels were of concern.

Audits were carried out, but were not always effective in all areas.

People attended meetings and were asked for their feedback on the service.

Lyndon 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to an external investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks. The incident has been brought to the attention of the Police and a Local Authority. Other issues raised prior to the inspection were around staffing levels and care provided to people.

This inspection took place on 07 June 2018 and was unannounced. The inspection team consisted of three inspectors, a specialist nurse advisor, a pharmacist and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. We received a Provider Information Return. This is information we require providers to send us at least once annually 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.

We spoke with twelve people who lived at the home and four relatives. As some people were unable to tell us their views of the service, we completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with ten members of staff, the cook, the turnaround manager, the manager and the quality director.

We looked at the care records for nine people as well as twenty one people's medication records. We checked records held in relation to staff recruitment and training, accidents, incidents, complaints and

systems in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2017, we found people experienced risks related to staffing numbers and skin care and turning. We checked to see if improvements had been made and found that whilst the support staff provided to people to reposition them had been improved the monitoring of skin issues were not always carried out adequately and we found that people remained at risk because staff were not always available to people resulting in lack of appropriate care.

We found that the general opinion of people, staff and relatives was that there were not enough staff available to people to keep them safe. One person told us, "They need more staff. It's grossly short staffed. We have to wait too long. If you want to go to the loo you have to wait too long, or you just pee in your pants. The management company needs a kick up it's backside". A second person told us, "Sometimes there are just not enough staff, especially not at night. This means you are kept waiting because staff are doing other things". A third person shared, "You keep buzzing, but they [staff] won't come in the day and I play up until I get up in the morning" [as staff keep me waiting]. A relative told us, "Staff try really hard but there is often not enough staff to keep people safe". Staff members commented the following; "It feels understaffed, there should be a floater [extra staff member] on each floor. There are too many roles to carry out, an extra member of staff would make a difference". "We don't have time to be with the residents. We have good staff but we need more on each shift; people are safe but things do get missed because we are so rushed, such as, being turned or getting a drink".

We asked people why they felt there was a problem with staffing and they told us, "There are a lot of staff changes and it is difficult to get used to someone as they often leave. I think this is because they don't get paid enough and there is not enough staff, so staff leave". "They have some very good staff but they have lost a lot of them. They are always advertising. They don't treat them right". A staff member told us, "I feel bad sometimes as it's hard to find the time to do paperwork and fulfil everyone's care needs. I try to prioritise care needs but completing all the records is very time consuming". We found that agency staff were used at times when staffing levels were low. A relative told us, "Occasionally they have agency staff, new faces, who are not always suitable". A staff member said, "We have agency staff, but always ask for familiar ones, if they are not up to the job then we won't ask for them again or say to the agency don't send them".

We found that staff were not always available to people when they required them. Incidences included where a person told a staff member they were thirsty and would like a cup of tea, but the staff member dismissed this and rushed out of the room. Also, where people were left in the dining rooms for considerable periods of time and told us that they wanted to mobilise elsewhere, but no staff were around to assist them. We spoke with the turnaround manager about staffing and were told that staffing numbers for that day were in line with the providers best practice guidelines. However, managers were unable to tell us where staff might have been when they were not supporting people, so they were not fully aware of where staff were deployed.

We were told that recruitment was in progress and recently some unsuitable staff members had been

dismissed. We had previously been informed at the last inspection and ones previous to that, that recruitment was actively commencing, but we saw no improvement in overall staffing and the recruitment and retention of permanent staff rather than the use of agency staff. The turnaround manager felt that this could be related to the inconsistency in management recently, but that having a long term registered manager in place may encourage staff to join the service and stay in post. Staff told us that prior to starting work, they had been required to provide their work history, references from previous employers and complete a check with the Disclosure and Barring Service (DBS). The DBS check would show if a person had a criminal record or had been barred from working with vulnerable adults. Records we looked at showed that these checks were in place.

We looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 21 people, speaking to staff and observing how medicines were administered to people. We found the administration records for the oral medicines were good and were able to demonstrate people were getting their medicines as they had been prescribed by their doctor. However we found that a person who required one of their medicines to be administered at specific times of the day was not receiving this medicine at the times specified. We also found that there was no monitoring system in place for those people who left the service to spend time with their family. The service is unable to ensure medicines are given correctly whilst away from the service. However a monitoring system would identify if there was a problem with the administration of the medicines and the service could take appropriate action to ensure any risks to the people concerned are mitigated. We observed members of the nursing staff supporting people to take their medicines. We saw it was done with care and followed safe administration procedures.

We looked at the information available to the staff for the administration of when required medicines. We found the when required protocols were not as detailed and did not explain what the terms such as "agitated or aggressive" meant and looked like for the individuals concerned. We found a number of people had been prescribed a sedative medicine on a when required basis to treat their anxiety and/or aggression. When these medicines had been administered we found little or no written evidence that demonstrated the need for their administration. We spoke with a staff member about a person who had been prescribed two sedative medicines on a when required basis and asked them to describe the circumstances when choosing which sedative medicines to use. The member of staff was not able to describe with any confidence how the choice was made. The provider was therefore unable to demonstrate that these sedative medicines were being administered appropriately.

We found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely. We also found that where people had to have their medicines administered by disguising them in food or drink the provider did not have all of the necessary safeguards in place to ensure these medicines were administered safely. For example, we found the provider was not able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that there was no written information to tell staff how to carry out this process safely and consistently.

Some medicines were not being stored securely. For example, we found topical medicines were being stored in people's rooms without the appropriate security measures in place. This meant other people using the service could inappropriately use these products. We also spoke to a person who according to the administration records had been prescribed a pain relief gel and was having it administered three times a day. This person told us that they were not having just one gel applied but was having two different gels applied and was having them applied only when they needed them. A number of topical cream body maps had no clear instructions for staff on how to use them and there was also evidence that creams were not

being applied as prescribed, for example, topical cream prescribed twice daily, this was being administered mainly once daily, this was the case for several the body maps that were reviewed.

We found two out of the three refrigerators we looked were not being monitored correctly to ensure medicines within them were stored within the correct temperature range. We found staff on Rose unit were not measuring and recording the maximum and minimum temperature on a daily basis. We found on Poppy unit that staff were pressing the wrong buttons to obtain the maximum and minimum temperatures and therefore inaccurate temperature reading were being recorded. On the day of the inspection we found the minimum temperature of the refrigerator was zero degrees Celsius. We found that the refrigerator was storing a temperature sensitive medicine called insulin. With the distinct possibility that this insulin had been frozen the provider was advised to obtain a new supply of the insulin and then discard the current stock. Medication can be adversely affected by being stored at incorrect temperatures.

Following the inspection the acting manager sent us an action plan of how they would be immediately addressing some of the concerns relating to medicines and the recording of skin issues.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place for when people had been assessed for risks such as, skin checks, diet, food and choking risks and moving and handling and falls amongst others. Records showed the level of support required and the equipment to be used to assist the person safely. Staff we spoke with knew about people's individual risks. They were able to explain the actions they took and the equipment they used to enable them to support people safely. Where people required equipment we saw that it was in place. We found that risk assessments had been updated as required. There had previously been a choking incident where a person had sadly subsequently passed away, the acting manager informed us of the steps that had been taken to minimise any further risk to people, such as the providers hospitality team attending on an ongoing basis to support staff in learning how to assist people with feeding appropriately.

Previously, we had concerns around people with skin issues not being turned appropriately, however whilst a small number of people still had some gaps in the records that showed how often they had been turned, we found at this inspection that things had been improved upon. However, we found that where people may need to have their skin monitored more closely this was not always carried out effectively, as where photographic verification of skin issues may be required in order to evidence if there had been any changes in the wound, the camera was broken. This would mean that the required processes may not always be followed, for example different staff members treating the wound would not have evidence to compare if there had been any changes. Good practice would suggest that regular photos should be taken to identify potential improvement within the wound. The manager informed us that there was only one camera, which was also used for activities and this was broken, but a new one would be in place as soon as possible.

People told us that they felt safe with one person saying, "It's not too bad. I feel safe here". A second person said, "I feel safe". A relative told us, "On the whole it is safe but there can be aggravation sometimes [between service users]. There is one resident who kicks off hard if his needs are not met. He becomes confrontational and if he shows aggression towards the women, my [relative] feels he has to step in [but it shouldn't get that far]". A second relative told us, "I've had issues, but I can't fault any staff. They [management] should be looking at what the minimum staffing needs should be because people with dementia have such diverse needs. Dementia needs are becoming more and more intense. Because of that they [management] don't realise the strains on staff".

Staff could tell us how they would recognise potential signs of abuse and how they would report these concerns. The staff reported that the service had a whistle blowing policy in place, staff were also aware of the safeguarding process if they were required to implement this for residents, whilst within their care. One staff member stated that, "I would raise any concerns with my manager, I only had safeguarding training two months ago, so I know the signs and symptoms, such as changes in behaviour".

We looked at people's PEEPs (personal emergency evacuation plans). We found that the folders that were reviewed had PEEPs in place. This meant that staff would know how to support people to leave the service in the event of a fire or other serious incident.

We found that the home environment was clean and that environmental checks were in place to ensure the safety of people. A relative told us, "The home is always clean". A staff member told us, "The Housekeeper manager is very good and has been here for 25 years, she knows the job and is a real stickler for detail". From observing several areas, during the inspection period, lounge areas, dining rooms, corridors and bedrooms, the areas were of an acceptable standard in relation to decoration, however a number of people had commented that the décor was 'tired'. The home had no odours that are associated with poor hygiene levels, or poor cleaning regimes. All checks related to the environment such as fire and gas and electricity safety checks were completed as required.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in May 2017, we found shortfalls in the provider's systems to ensure people received effective care. This resulted in the provider being rated as Requires Improvement in the key question of Effective in particular in relation to food and nutrition and the sharing of information between staff members. We checked to see if improvements had been made and found that whilst efforts had been made to ensure greater clarity of information, there were mixed views on the food and drink people received.

People commented on the food saying, "It's all right, passable. Not so good. You only have what's on the menu". A second person said, "It's [derogatory term]. The food needs improving 100%". A relative told us, "The food is not always suitable and the meals lack planning. [Relative] is not handy at cutting food up, so a pork chop might look good but what's the point of giving it to him? The staff are busy, but if I ask them they will cut it up". Staff were generally very complimentary with regards to the food and told us that people enjoyed the food. One staff member told us, "Yes, the food is good". We saw that some people were unhappy with the single choice of mashed potato to accompany their meal.

We saw that one person did not like their meal, so was offered a second option of lamb. However, lamb was not on the menu as an option and the meal offered was actually liver and bacon so this was misleading, but the person trusted what the staff member was telling them. The menu was on display and some people had food in their rooms with relatives or in the lounges, their food was covered appropriately. One person did not like hot options so they were given a choice of a sandwich of their choice and another person was being taken out by relatives and was given a packed lunch to take with them to ensure they had something to eat. Following a recent choking incident staff told us that changes had been made and that now any pureed food coming from the kitchen was labelled with directions for the staff support needed and information boards within the office gave staff a visual prompt as to people's needs including those linked to feeding and nutrition. Staff also told us that they had received recent training. One staff member told us, "It frightened everybody, just how easily people can choke, so we are all extra careful now".

We saw that throughout the dining rooms there was a list on display which had peoples' names and their dietary requirements. There was no evidence to show that people had agreed to this information being shared where others could see it. Staff members were knowledgeable on who required pureed, fork mashable or a normal diet. We were also told about specific menu's offered to people, such as vegetarian, Asian food or halal food for people from various ethnicities. We found that throughout the day drinks and biscuits were available to people.

We found that one person who was fed via a Percutaneous Endoscopic Gastrostomy [PEG], had differing documentation recorded that could lead to confusion. Some information shared that they could have five teaspoons of liquidised food, however others said 'small amounts'. This gave different impressions of what could be given safely. Staff spoken with were unable to provide us with a clear definition of how much food was given. The manager said that they would look into this and ask for guidance from professionals.

People's weights were being monitored and we saw that for some people, any identified weight loss was

being acted upon. People's dietary likes and dislikes were recorded in their care plans. People's care plans also included information on their nutritional needs and any assistance that people required to eat. Staff told us, "If anyone requires assistance to eat we will provide this and will cut up the food if required". Another staff member shared, "If there were concerns regarding people's dietary intake this would be shared with the nurses or the manager".

At this inspection we found that communication between staff had been improved upon and that the use of the information boards were noted by a number of staff as being useful. We saw that most staff members were knowledgeable on people's needs and the majority could speak to us about people's requirements and why they were in the home. A staff member told us, "We communicate as much as possible, and it is useful as we need to know how best to care for people".

We observed staff communicating effectively with people, using different ways of enhancing communication. For instance, by touch, ensuing they were at eye level with people who were seated and altering the tone of their voice appropriately. Where a person did not respond positively to one staff member, they moved away, and another staff member took over. Staff told us they found this approach of a 'different face' worked for many people who declined or rejected care or support initially. A member of staff told us that they still like to make contact with people who are non-verbal just with a touch to the side of their face to let them know they are there.

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

We found that there had been a 'blanket application' for DoLS of all people living within specific units, regardless of whether it was thought that they had mental capacity or not. This had resulted in a large amount of applications for people to be deprived of their liberty being refused by the appropriate external agency. The turnaround manager informed us that this was not their personal policy, nor was it that of the new manager and a policy was now in place where only people thought to lack mental capacity would be assessed in relation to DoLS. Upon speaking with staff in relation to their knowledge with regards to DoLS, they could recall some aspects, however not all main points. One staff member told us,"It's when people are not safe, as the doors are locked". We shared this with the manager who informed us that training had taken place recently and they felt that the staff may be confused under the pressure of an inspection. Staff were not aware of who did or did not have a DoLS authorisation in place and without this knowledge we could not be sure that people would be supported in line with these authorisations and any additional conditions.

Staff displayed an understanding of how to seek consent prior to supporting people and we saw them put this into practice. A relative told us, ""Staff always tell [relative] beforehand what they are going to do, especially with personal care. He's not going to answer [because he is non-verbal], but they talk him through each step any way". One member of staff told us, "I don't assume that someone doesn't have capacity, I will find out". We saw staff seeking people's consent prior to supporting them. For example, we saw staff asking people before providing their medication support. However, this was not to case in all instances and we observed a staff member, walk up to a person without informing them that they were going to wipe their

nose and they grabbed the person's nose sharply with a tissue, which resulted in the person becoming somewhat dazed by the experience.

There was a mix of opinion from people on whether staff had the skills needed to support them effectively. One person shared with us, "Some of them [staff] have, but some of them are learners and they're not fully qualified. This chap had to strap on my catheter this morning. He had no idea and I had to tell him how to do it". Other people had a difference of opinion, saying, "They [staff] know I get anxious in the hoist, so they help me". Relatives we spoke with told us, "Yes, I do think the staff are effective. I'm familiar with [person's names] dementia and I'm allowed to be involved. They explain to me what's being done. They talk to me about any fears I might have. They don't bombard me with information but they tell me if I ask". Similarly, another visitor said, "When somebody needed first aid, the staff responded and had a good idea of what to do".

Staff told us that before they could start work, they had been required to complete an induction and training. One staff member said, "I shadowed for two weeks and completed some e-modules including safeguarding and manual handling". A staff member told us, "I get regular supervision and my appraisal is due soon. If I am unsure about anything, I can openly go and ask for advice and support from managers". A second staff member said, "There is regular supervision. I know I get watched when I am working to make sure I am doing everything right and this is okay". We saw that the staff matrix listed training that staff members required and one staff member told us, "I get enough training to enable me to do my job well".

People had access to healthcare professionals such as GP's, dentists and chiropodists. A person said, "If you are not well you just tell the staff and they get the doctor to visit. I have my own chiropodist visit me." Another person told us, "You talk to the nurses if you want to see a doctor." Nursing staff told us that they were able to liaise with health professionals if necessary. Staff were asked, how would they access services for people, who had sudden deterioration, one-member staff stated "If there are signs of a person not being well, "I would observe them and I would contact the GP for advice or to visit if the symptoms of the person were not critical, however if the person is showing signs of becoming critically ill then I would call 999". One staff member informed us that people are weighed monthly, therefore, we reviewed people care folders, in relation to weight, there was evidence to suggest that people were weighed monthly and weights of people had mainly been stable, with little fluctuations.

The decoration of the service could be improved to benefit people with dementia type illness. Although there were some colourful displays around the home there was little signage in relation to areas such as toilets and in the specific 'dementia' units the corridor lights were dim, rather than being slightly brighter, to enable people to have a brighter area, to wander with a purpose. All bedroom doors had slots for people's name and photographs, but not all of them were utilised.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2017, we found shortfalls in the provider's systems to ensure people were treated in a caring way. This resulted in the provider being rated as Requires Improvement in the key question of Caring. We had previously had concerns around people being left in their bedrooms for long periods of time and belongings going missing. We checked to see if improvements had been made and found that although some people remained in their bedrooms this was largely down to choice or to maintain their wellbeing, for example someone feeling ill. We found that people's belongings were now cared for better and this was no longer a concern raised by people.

There were mixed reactions to whether staff were kind and caring towards people. Some positive comments from people included, "They [staff] are very good to you all the time" and, "I can't fault the nurses and carers. The lady who does the laundry also comes in to check if I'm okay. They are pushed because they have a lot to do", and, "The girls [staff] are very friendly, but some come in rushing and I can't rush". However people also noted, "90% of staff go out of the way to make sure everything is okay and I respect them for that, but never 100% of them". Other comments included, "You need more staff, better staff. Not all of them are happy here and it shows" and, "Staff are not always around when you need them". A relative told us, "I have a lot of respect for nurses and carers. They are on the go for 12 hours." A staff member told us, "I have been here for about five years, yes the job can be difficult at times, but this is what I came into the job for, to care for people".

We saw some examples of positive interaction with people, including, staff joking with a person about them wanting a glass of cider and the staff member said they would find out if the person could have one and would get them one if it was possible. Staff were also observed to respond to people positively in some cases, in particular at times when people asked for assistance or if they were emotionally distressed. When a person asked for the radio to be turned up, we saw staff responded immediately. We also viewed situations where staff were not so caring towards people, including where a person was trying to make small talk with a staff member in the dining room and they commented on how nice the lemonade was and asked what make it was. The staff member abruptly replied that they 'didn't know' and shut the conversation down, despite the lemonade being within their easy reach. The inspector informed the person of the make of the lemonade and they showed a real interest in holding a conversation. We also saw another example where the same person asked the staff member what an item was [drink thickener] and they told them something completely incorrect, so that they did not have to offer a detailed explanation. We informed the manager of this and they told us that this was an agency staff member and they would not be using them again.

We found that whilst some staff members maintained people's privacy and dignity, others did not. One person told us, "They [staff] are good and they treat you with respect". We saw that some staff addressed people respectfully and used their preferred term of address. Staff also told us that they tried to be discreet when assisting people, for instance putting a blanket over someone who has a catheter. However, we observed that staff did not always take action to protect people's dignity. For example, one member of staff identified that a person required to use the toilet and this was discussed openly within the lounge area with another staff member stating loudly that the person wanted the toilet. We also saw on Rose unit people

walking aimlessly around the corridor with no staff in sight. At one point four people were huddled together at the far end of the corridor and they looked unkempt with uncombed hair. These people were covered in their own secretions and scratching themselves. After a period of time a staff member appeared and steered them back towards the lounge, but one person's dignity was not maintained as the wet pad that they were wearing fell to the floor in full view of the others.

Again on the Rose unit the lounge was hot and the air was stale because the windows were closed and it was a warm day. We saw that one person was agitated and said emotionally, "They [staff] won't listen to you. This is hopeless this is". However, instead of reassuring the person, staff instead tried to give us an explanation for the person's behaviour and told us, "As the residents aren't 'all there' she is finding it difficult here. Most people have dementia and she is the only 'normal' one here". One staff member then made a gesture with their index fingers either side of their head in a circular motion in order to reinforce their view that people were mentally unwell. The person continued to be ignored by the staff members, which frustrated them more. Throughout the day on all units we saw little positive interaction between people and staff, except for times when staff carrying out activities were encouraging people to become involved.

People told us that they were given choices. One person said, "I don't get the food that I want, but I do get a choice of which meal I want on that day". A second person told us that they had chosen the outfit they were in that day and a third person said, "I choose what time I get up, it is up to me". We saw that people's choices and views were recorded in their care plan and where a person had requested female only carers staff were aware of this.

We found that people were supported to be independent and that most people were encouraged to eat their meal in the dining room alongside others. One person told us, "I can do everything for myself, so I do, it keeps me active". A staff member told us, "We ask people what they can and can't do and will help if they get stuck with anything". We saw that a number of people had a mobility care plan and that staff assisted people to walk with the use of equipment to encourage independence. We also saw one staff member taking the initiative when they saw people struggling to eat with a knife and fork and then offering them a spoon, which helped them to eat their food independently.

Where people required the use of advocates this was facilitated. An advocate assists people to ensure that their opinions and viewpoints are heard.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017, we found shortfalls in the provider's systems to ensure that people received adequate stimulation in the form of participating in activities and that people were not always knowledgeable on how to make complaints. We found that whilst there had been some improvement in the frequency and content of activities this was still 'a work in progress'. However people were now more aware of the complaints process and how to access it.

There was a mixed response to questions around activities. Some people were satisfied with the activities the service provided but others said they would like more. One person said, "Yes there are activities, depending what you like to do". On the day of the inspection, there appeared to be limited resources in relation to providing activities for those wishing to participate with some people sat around with nothing to do. One person told us, "It is hit and miss they [staff] are trying, but it's just not great". We saw that there was entertainment on Fridays in the form of singers, there was also an armchair exercise programme and on the day of inspection and a dog was brought into the home and people were very happy to see it. Staff members told us, "We need to put more hours into activities and the provider needs to see the value in them and importance of them. Staff having to do other things takes the time away from activities, but some relatives have said that they would be happy to help out with activities". We saw that the activities co-ordinator engaged in very positive interactions with people and the exercise sessions were well attended and filled with lots of laughter. However, for those who chose not to participate they experienced little stimulation. An example being on Sunflower unit the television channel stayed on the same continuous rolling news channel all day with no change and people sat about either sleeping or looking bored. Although staff told us that people were taken out into the community, we did not see evidence of this, nor could people tell us if this had occurred. People's care and support plans included only limited information on their hobbies and interests. Activity plans were in place showing how people spent their time, but these mainly covered the basic activities we saw in place such as the armchair exercise or people listening to the regular singer.

People knew how to make a complaint if required. One person told us, "I just speak to the carers and it gets resolved quickly". Another person said, "If it's a small matter I will speak to the senior on the wing. If it's urgent I go to the manager upstairs straightaway and we sit down and discuss. On the whole issues are resolved but not always". One person had not been happy with the way complaints were dealt with and told us, "I have complained to the head office a few times. It fell on deaf ears. Everything here needs improvement". We found that one complaint of poor standards of care was in progress and not yet resolved. The complaints file recorded all appropriate information and the action taken. We saw that there were also compliments sent into the service and a recent one said the turnaround manager was. "The best manager ever!".

People could not recall whether they had been involved in the planning or review of their care. A relative told us, "Yes I was involved in [person's names] care plan and the reviews". Care plans we looked at were individualised, however they were not detailed, for example one person who was diabetic did not have a care plan which was specific to their needs. We saw that care plans were reviewed regularly therefore changes within the person's physical health and mental health were addressed in a timely manner. We saw

that staff had access to people's care records and they informed us that any changes in the plan were discussed at handover sessions. Care plans looked at people's nutrition, health and medication and skin viability amongst other elements. We saw that where required turning charts, body maps and food and fluid charts were in place.

We saw that care plans looked at people's preferences including likes and dislikes. Examples of this included one person preferring a vegetarian diet and no eggs, which is what they were provided with. Some people requested to listen to ethnic radio stations and this was in place, whilst others requested to wear their own jewellery and one person also preferred to be addressed by a specific term of endearment and we saw staff use this.

We found that plans in place for when people came to the end of their life were not always detailed in relation to people's preferences, however Do Not Resuscitate [DNAR] orders were in place and these had been discussed with family and professionals involved and signed as a true record. Staff were aware of who had a DNAR in place. We found that some people coming towards the end of their life also had anticipatory medicines in place should their health decline rapidly.

Requires Improvement

Is the service well-led?

Our findings

We saw that some quality assurance audits were in place and that they were completed regularly, an example being that audits covered the environmental wellbeing of the home and we found that any related concerns were addressed. However, whilst they had also been effective in identifying issues such as patterns in people's weight loss and gain and hospital admissions and health they had not identified some of the concerns discovered as part of the inspection. These included, the issues with medication storage (inappropriate fridge temperatures and lack of detail on MAR sheets), lack of detail in care records, in particular in relation to PEG and pressure area monitoring and lack of meaningful activities or stimulation especially for people who chose not to participate in groups. A concern that was raised continuously throughout the inspection by people, relatives and staff was the lack of adequate staffing. During our inspection we found people were left for periods of time without staff available to support them. Audits had not identified that staff routinely were not available to people and managers had no definitive answer when we questioned where staff were when groups of people with support needs were not always supported effectively. This meant that there was no system or oversight to ensure staff were deployed effectively. We saw numerous incidences where people were not treated in a caring and dignified manner by staff and people told us about their own concerns, but this had not been identified within audits in order to ensure that staff were more respectful towards people.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that accidents and incidents were responded to and recorded internally. Investigations took place where an incident was deemed to be serious enough to require it and in most cases where required appropriate external agencies were notified. However, we found that a small number of incidents were not referred to CQC, an example being where a person fell from their chair and sustained a bleeding laceration to the head. An investigation by management had taken place, but we had not been notified as to the incident or subsequent actions taken. The turnaround manager informed us that this had been due to the ongoing issues around management inconsistency and now the new manager was in place this would be resolved. The quality director informed us of how any incidents were scrutinised and that learning was taken from them, for instance if people were at risk of multiple falls the reason why would be sought.

At our last inspection in November 2017, we found that some people were unfamiliar with the manager and that some people were not informed of when meetings were taking place. We found that music stations played were not appropriate for an older audience. During this inspection we found that people were familiar with the turnaround manager, however as the acting manager was very new it was understandable that people had not had a chance to get to know her. People now told us that they knew when meetings were occurring. We found that staff were still playing music unfitting to the situation.

There was not a manager registered with us. The acting manager had recently been recruited and had been working at the service for only a few weeks. This manager was in the process for making an application to become registered and was awaiting an interview to discuss this further.

People we spoke with did not always know who the acting manager was although they were familiar with the turnaround manager. A significant amount of people told us that they were not aware that a new manager would be taking over. People told us, "What this place needs is a big shake-up". Relatives said, "I would say it's a work in progress" and, "They have lost some very good staff. The best ones have left". Staff told us, "[Turnaround managers name] is a gem she would bend over backwards to help people, but we don't know the new manager much yet, but she has introduced herself and I think she has the authority she needs to get respect from staff" and "I do hope things will improve with the new manager, as we have had few managers over the years". The acting manager told us, "I can feel it [the service] improving, the nursing team are good enough to take some control and we have some good nurses and staff and open lines of communication".

We were told about the Lyndon Hall committee, which interested parties including people and their family members were invited to attend, to enable them to have input on dealing with issues related to the service. Staff members told us that the turnaround manager had an open door policy in place where they could approach her at any time for discussions and that they hoped this would also be a policy of the new manager. Staff members shared that they had been kept updated about the ongoing recruitment process. Staff we spoke with understood the leadership structure and the lines of accountability within the service; they were clear about the arrangements for whom to contact out of hours or in an emergency.

People were now aware of when meetings were taking place. We saw that meetings were arranged for staff and they told us that they had an opportunity to share their opinions and views. A staff member told us that their suggestions for activities had been acted upon by the provider and some were now in place and they were hoping to see more implemented. The latest agenda centred around, 'making the home the best that it can be'. Residents and relatives meetings were also attended and these included topics such as, activities, have your say, recruitment and staffing.

We found that staff were still playing inappropriate background music and we heard heavy metal music played loudly in a room where most people had a Dementia type illness. Although people were unable to verbally communicate that did not like the music we saw that some people looked uncomfortable and there is a possibility that such noise was a sensory overload. The music was being played in a room where a number of people were sitting, so it was doubtful that this was the collective music of choice. At no point did any staff member take any action to change the music. We told the acting manager of this and checked later and the music was no longer being played. This is a concern that we had also found on our last inspection, although previously it was within a different room.

We saw that people had been given opportunity to provide feedback on their experience of the service and a survey was carried out in February 2018, with another now due. Responses included concerns around staffing levels and lack of activities. The acting manager told us that attempts had been made to address these concerns, with the ongoing recruitment and a part time specific activities co-ordinator, but shared that there was still some way to go until they would be satisfied that things were all in place. Feedback we saw taken from professionals was positive including; 'I visit the care home weekly to support staff with resident care since [turnaround manager's name] has been in post things have greatly improved staff are motivated and seem less stressed. The atmosphere is calm and relaxed.

Staff members knew the process to follow if they had needed to raise concerns about a colleagues' working practices. They understood the provider's whistleblowing procedure and their responsibility to pass on information of concern. Staff were aware of other organisations they could approach if they felt that the provider did not take the appropriate action. One staff member told us, "I am very confident, if I bought a concern to the new manager that this would dealt with by the new manager". A whistle blower contacts an

external safeguarding agency to share any concerns they may have about care and practice within the area where they work.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any websites ran by the provider in relation to this home. We saw that the provider had displayed their rating in the home and on the website, so had met this requirement.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being stored or administered appropriately. Information was not available to staff to support people who required medicines and nutrition given directly via a PEG.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of good governance meant that managers did not have an understanding on how staff were deployed and audits did not identify issues raised within the inspection.