St Martin's Residential Homes Ltd

The Leys

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Leys is a residential care home that can provide care and support for older people and people living with dementia. The service is registered to provide accommodation and personal care to a maximum of 33 people. At the time of inspection 12 people were using the service.

People's experience of using this service and what we found
Risks to people had not always been mitigated. We found risks associated with water temperature, food temperatures, environment and equipment.

Risks associated with people's health conditions were not always thoroughly assessed and mitigated. People with risks from known health conditions did not always have details recorded and factors to reduce the risks were not always identified or followed.

Effective systems were not in place to protect people from the risk of potential abuse. Safeguarding procedures had not always been followed. Records of injuries were not detailed and follow up checks were not recorded.

Records of injuries and accidents were not always reviewed by the manager, to identify concerns and improve practice when needed.

Records did not evidence that staff supported people with all of their individual needs, such as continence tasks or personal hygiene tasks.

Medicine management required improvement. Records were not always clear regarding which medicines were currently prescribed. Reasons for administering as required medicines were not completed.

Systems and processes to provide oversight of the service were ineffective in identifying improvements needed. Concerns found on this inspection had not been previously identified or mitigated by the provider.

The provider had not always followed the requirements under the duty of candour. The duty of candour requires registered providers and registered managers to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.

People and relatives told us they were supported by staff who knew them well and had been trained to meet their needs. People and relatives were positive about staff.

People were supported to have maximum choice and control of their lives but staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service

did not always support this practice.

People, relatives and staff all knew how to complain and felt their concerns would be dealt with appropriately. Feedback was requested from stakeholders.

The service had received a five-star food hygiene rating on 12 April 2022 from the food stand agency.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 1 February 2022) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed from inadequate based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk mitigation, records, medicines and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will

re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Leys

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience made calls to relatives.

Service and service type
The Leys is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. The Leys is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and nine relatives about their experience of the care provided. We spoke with seven members of staff including the provider, manager, and care workers.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke to two professionals who work with the service.

Inadequate

Is the service safe?

Our findings

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

The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

At our last four inspection the provider had failed to ensure people's risks were being assessed and managed appropriately. This was a breach of Regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had made some improvements. However, they were insufficient and were still in breach of regulations.

- People were at potential risk of harm from known risks. For example, some risks had not been assessed or mitigating strategies identified. When strategies were recorded, we found records did not evidence that these had been completed. Two people required regular checks to support with risks relating to continence, we found no evidence of these checks being completed or the support being offered.
- People were at risk from unmanaged health conditions. For example, the food records for one person who required their diabetes to be managed through a low sugar diet evidenced staff often recorded they ate chocolate, biscuits and cakes. Staff told us the service did not have diabetic cakes, biscuits or chocolate. The records did not include how much food the person had eaten. This put people at risk of unmanaged diabetes.
- People were at risk of scalding. Not all water temperatures (from hot taps) were taken. When the temperatures were recorded above the Health and Safety Executive (HSE) recommended temperatures, there was no evidence of actions taken to reduce these to safe levels.
- People were at risk of pressure damage. When people required support with repositioning to reduce the risk of skin pressure damage, records showed these tasks were not completed within the specified time frame. For example, one person required support to reposition every two hours. Their records evidenced gaps of over five hours leaving the person at risk of pressure damage in that time period.
- Safeguarding systems and processes did not always protect people. We found three incidents of harm to a person that had not been reported to the local safeguarding authority in line with the providers policies.
- Records of people's injuries did not always contain sufficient details for staff to continually assess their healing. For example, records did not include the shape, size or colour of bruises. There was no follow up information recorded to identify if an injury had healed or required additional healthcare support. This put people at risk of harm from unmanaged injuries, and the potential risk of unmanaged worsening injuries.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us that people felt safe within the home. One person said, "I have never been hurt and I feel safe with staff."

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had made some improvements. However, they were insufficient and were still in breach of regulations.

● Medicine records required improvement. One person's medicine administration record (MAR) had a medicine recorded as 'not available' on five occasions, refused on one occasion and not given as asleep on one occasion. The manager informed us this medicine should have been stopped eight days earlier but had not been recorded on the MAR chart. This put people at risk of not receiving their medicines as prescribed.
● When people required 'as required' (PRN) medicines, staff had not recorded the reason for administering the medicine. This meant any health professional assessing the person's use of the PRN medicine would not be able to assess its effectiveness.
● One person who required a PRN medicine to reduce the risk of constipation had the medicine administered on two occasions when records evidence this medicine was not needed. Staff had not followed the PRN protocol, which put this person at risk of unnecessary and potentially distressing symptoms. Staff had not administered medicines as prescribed.

The provider had failed to ensure the proper and safe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The manager shared an overview of incidents and accidents after the inspection. However, not all incident forms had been analysed to ensure lessons could be learnt and information shared with staff.

Preventing and controlling infection
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises or preventing visitors from catching and spreading infections. Records of high touch areas being cleaned were minimal. Some days records only evidence high touch areas being cleaned once throughout a 24 hour period.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● The provider had already identified concerns with the completeness of some staff files and evidencing safer recruitment checks were documented. The provider had already requested additional information for

specific areas where concerns were found. The staff files we looked at contained evidence of references being received and Disclosure and Barring Service (DBS) checks being completed before staff started to work at the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Staffing levels were appropriate to meet the needs of the people currently being supported at The Leys. People relatives and staff told us they felt there were sufficient staffing to meet people's needs. One relative told us, "I go in regularly and [person] is happy and well looked after." Another relative said, "When I go in, they [staff] are always chatting with [person] and having a laugh and I know it's real. [Person] is content, [person] is happy and smiling."

Visiting in care homes

● The provider followed government COVID-19 guidance on care home visiting. Staff checked visitors lateral flow test result and their body temperature. Visitors were given appropriate PPE.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

● People were supported to make decisions. When a person lacked the capacity to make a decision a best interest meeting was held. Relatives told us they were involved in decisions when appropriate.

Inadequate

Is the service well-led?

Our findings

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

The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

At our last five inspections the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had made some improvements, however they had not made enough improvements and were still in breach of regulations.

- Concerns raised on previous inspections regarding oversight and systems and processes had not been embedded into practice. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.
- Systems and processes were not in place to ensure people received safe, effective care. The provider did not audit records relating to daily support tasks needed. For example, we found gaps in the recording of supporting people with showers or baths, oral hygiene, continence needs and wellbeing checks. This put people at risk of neglect and harm.
- Systems and processes were ineffective in identifying and mitigating environmental or health and safety concerns. For example, we found one window restrictor was not in place, one wardrobe was not attached to the wall and food temperatures were not consistently recorded. This put people at risk of significant injury from wardrobes falling on them, leaving the building unnoticed and being served unsafe food. The provider rectified the window restrictor and wardrobe after the inspection.
- Systems and process were ineffective in ensuring risks were mitigated. Water temperatures and repositioning records were not audited. We found concerns in both these areas during the inspection. This put people at risk of harm from scalding and skin pressure damage.
- Systems and processes were not effective in ensuring infection prevention and control procedures were followed. For example, the provider did not monitor or identify that high touch areas were cleaned frequently. This put people at risk from infections.
- Some of the issues identified during the inspection had been raised as concerns by the local authority in previous months. For example, high touch areas not being recorded as cleaned was raised with the provider in January 2022. Incidents not being analysed had been raised in February 2022. The provider had failed to learn from this feedback.
- Although we found some areas of the service had improved on this inspection, we found similar concerns

that had already been raised on previous inspections. Improvements had not been sustained and embedded.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (2)(a) (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager had not followed the duty of candour as required. We found three occasions were the duty of candour process should have been followed. However, there were no written records to evidence they had followed the providers policy. The manager completed the duty of candour process immediately after the inspection.
- People and relatives told us they knew how to complain, and complaints were dealt with appropriately. One relative told us, "I complained, and the manager apologised and sorted it for me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, relatives and staff were involved in people's care planning. A relative told us, "I helped draw up a care plan on several occasions."
- People, relatives, staff and visiting professionals were asked for feedback about the service. We saw evidence of surveys being completed to allow people to voice any improvements required.
- We received positive feedback from visiting professional. One professional told us, "The manager is interactive and approachable. [Manager] is happy to liaise with us and deal with any issues."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Notice of Decision served to close the location. However, the provider deregistered with CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Notice of Decision served to close the location. However, the provider deregistered with CQC.