Angel Care Homes Limited

The Leylands - Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Leylands is a residential care home providing personal and nursing care to 17 people at the time of the inspection. The service can support up to 21 people.

People's experience of using this service and what we found
People were not safeguarded from potential harm, abuse and neglect. People were not supported by staff who were effectively trained and had guidance in place to meet their needs. Medicines were not consistently stored safely and people did not always have guidance in place where they were prescribed medicines on an 'as required' basis. People were not supported by staff who were working in line with the government COVID-19 guidance on isolating following a positive COVID-19 test.

People were not supported in a consistent way during periods of anxiety or distress. People were not supported to have maximum choice and control of their lives and the systems in the service supported this practice. People and those important to them were not involved in the planning of their care.

People and their relatives felt able to feedback about their care. However, feedback was not consistently acted on to ensure improvements were made. People were not supported to communicate in line with their preferences. People's care plans did not contain information about their preferences.

The provider had failed to ensure there were effective quality assurance and oversight at the service to identify where improvements were required and to ensure these are embedded within the service.

People were supported to have choice around their meals. People were supported by staff who were recruited safely. People had access to activities they enjoyed. People and their relatives felt able to complain.

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

Rating at last inspection
The last rating for this service was requires improvement (published 12 February 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the quality of care and oversight at the

service. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led only. We did not review the key question of caring as this had previously been rated as good. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at 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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safe care and treatment, safeguarding people from potential abuse and neglect, compliance with the MCA, staff having sufficient and effective training, the leadership and governance of the service, failure to have a registered manager in place and failing to notify us of accidents and incidents at the service.

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

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

The Leylands - Residential Care Home

Detailed findings

Background to this inspection

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

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
The inspection team consisted of one inspector.

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

The service did not a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

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 and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff including the provider, director, senior care workers and care workers. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three professionals who are involved 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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to 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

- People were not safeguarded from potential abuse and neglect. At this inspection we found 11 potential safeguarding concerns that had not been referred to the local authority safeguarding team for review.
- Staff had an understanding of safeguarding however, where they had raised concerns, the provider had failed to identify where these constituted further investigation and referral to the local authority safeguarding team. This meant people were at prolonged risk of harm and neglect as the provider had failed to take action to keep people safe.

Systems were not in place or robust enough to demonstrate people were safeguarded from potential abuse and neglect. This placed people at risk of prolonged harm, neglect and potential abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Staff recorded concerns around people's behaviours on accidents and incident forms. We reviewed 27 accidents and incident forms that had been reviewed by the management team. However, all of these reviews were incomplete and no action had been taken following these reviews to reduce the risk of incidents reoccurring. This placed people at prolonged risk of harm and enabled a culture of acceptance to abuse within the service.

Assessing risk, safety monitoring and management

- People did not have care plans or risk assessments in place which identified health related risks and gave guidance for staff on how to mitigate these. For example, one person had a diagnosis of diabetes and had experienced episodes of low blood sugars resulting in them becoming unwell. However, the person had no diabetes care plan or risk assessment to enable staff to support them safely. This placed the person at risk of serious harm through staff not recognising deterioration in their diabetes and taking timely action to support them safely.
- Where people experienced periods of agitation and anxiety, staff did not have guidance in place to support them during these periods and to mitigate any associated risks. For example, four people had experienced multiple episodes of increased anxiety, one of which had experienced 10 periods of increased anxiety between August and November 2020. However, they had no care plans or risk assessments to reflect this and guide staff on how to support them safely. This placed these people and those around them at risk of harm.
- People did not consistently have guidance in place to enable staff to support them in the event of an emergency, such as a fire. The provider responded following the inspection to ensure all people had this

guidance in place.

Preventing and controlling infection
● The provider had failed to ensure staff consistently followed government COVID-19 guidance. For example, one staff member had been told they were required to remain at work following testing positive for COVID-19. Another staff member was encouraged by the management team to return to work following being in contact with a person who had tested positive for COVID-19.

Systems were not in place or robust enough to ensure people received consistently safe care. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, staff were wearing PPE appropriately and sanitising their hands regularly.
● The service was clean however there were areas of the home that required organisation. For example, the linen cupboard was disorganised.

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

Using medicines safely
● At the last inspection we found improvements were required to ensure medicines were administered and stored safely. At this inspection we found improvements had not been made and staff did not consistently have clear guidance to follow where people were prescribed medicines 'as required'. For example, five people did not have guidance in place. This placed people at risk of not receiving their 'as required' medicines as prescribed.
● Medicines were not consistently stored safely. For example, staff were not recording open dates on people's creams to ensure these were disposed of in line with their expiry dates.
● Despite this, we saw people's regular medicines had been administered as prescribed and had been reviewed by medical professionals where required.

Staffing and recruitment
● There was sufficient staff to meet people's needs in a timely way. For example, we observed people who requested staff support received this quickly.
● Staff told us they were recruited safely in line with the provider's policy. For example, staff told us they had received a criminal record check to ensure they were safe to work within the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● At the last inspection we raised concerns around people not having decision specific capacity assessments in place. At this inspection we found no improvements had been made. For example, three people had a consent form signed by the manager for staff to apply sun cream. However, no communication was recorded with the person, or those important to them to establish whether they could make this decision themselves, or whether this was the right decision for them.
● Two people had mental capacity assessments and best interest decisions completed. However, these covered multiple aspects of their care and were therefore not decision specific. There was also no evidence these assessments were completed in consultation with the person, those important to them or professionals involved in their care. This placed these people at risk of decisions being made about their care that were not in line with their wishes and the law.

Systems were not in place to ensure people received care and support in line with the MCA. This placed people at risk of harm. This was a breach of regulation 11 (Capacity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had training in the MCA and understood people should be supported make decisions around their care, where possible.

Staff support: induction, training, skills and experience
● Staff has not had training to enable them to support people with their healthcare risks. For example, staff

had not had training in diabetes or epilepsy, despite supporting people with these conditions. This placed people at risk of harm.
● Staff had not had effective training in dementia, despite supporting people living with dementia. We saw people living with dementia at the service often experienced distressed behaviours, however staff had not received training to enable them to support people effectively during periods of increased anxiety. During the inspection we observed staff had an inconsistent approach to a person experiencing distress, this resulted in the person experiencing a prolonged and increased period of distress and anxiety. This was a continued concern from the previous inspection.
● The provider had failed to ensure all staff supporting people had received basic training to enable them to do this safely. For example, one staff member was supporting a person on a one to one arrangement without any training. This staff member worked within the home but not as a carer. This placed the person being supported by the staff member at risk of harm.

Systems were not in place to ensure staff had sufficient and effective training to support people safely. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's physical, mental health and social needs were assessed prior to the start of their care. However as discussed within the domain of 'safe', people did not always have clear guidance in place to explore these needs and ensure staff had guidance to meet these safely.
● People, those important to them were not consistently involved in the assessment and planning of people's care.
● People did not have oral health care plans which gave staff guidance around how to support people to maintain their oral health care needs. This placed people at risk of a deterioration in their oral health.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to professional support to maintain their health and wellbeing where they required this. However guidance from healthcare professionals was not consistently recorded within people's care files to enable staff to follow this.
● Staff had a handover to support them to keep up to date with changes in people's needs.

Adapting service, design, decoration to meet people's needs
● The service required maintenance and update. Some of these updates had been delayed due to COVID-19.

● People were able to personalise their room should they wish to do so.

Supporting people to eat and drink enough to maintain a balanced diet
● At the last inspection we raised concerns around how people were supported to make choices around their meals. At this inspection we saw improvements had been made.
● People told us they enjoyed the food. One person told us, "We had omelette for lunch, I can't fault it."
● People were supported to maintain a balanced diet by staff. People could make choices around their diet. For example, we observed people being offered hot and cold choices of their main course on the day of inspection.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People did not have communication care plans in place which gave staff guidance on people's preferred method of communication to support their understanding.
- Where English was not a person's first language, people were not supported to communicate in their chosen language. For example, the provider had made communication cards to support a person's whose first language was not English, to communicate with staff. However, staff were not aware of these and there had been an instance where the person had not been able to communicate with staff that they had had a fall.

End of life care and support

- People did not have end of life care plans in place which explored their wishes and enabled staff to provide care in line with these.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not consistently have care plans in place which were personalised and explored their preferences. For example, people did not have cultural or religious care plans in place.
- People and their relatives were not always involved in the care planning process.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- At the last inspection we raised concerns around there being a lack of activities available for people. At this inspection we saw improvements had been made. For example, people were listening to music and playing seated football. We observed people really enjoyed spending time with the staff engaging with these activities.
- People were supported to maintain relationships which were important to them. For example, people had telephone calls with people who were important to them. Where people were not able to communicate verbally, staff spoke with people's families to keep them up to date. One relative told us, "They are keeping me informed. They let me know how they are getting on."

Improving care quality in response to complaints or concerns

● People and their relatives felt able to complain. One relative told us, "If I had concerns- I would think I could raise them yes. I think they would look into it." Where people had made complaints the provider had responded to in full to these.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure there was sufficient and effective quality assurance tools in place to ensure where improvements were required, these were identified and action was taken to embed these. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Quality assurance tools were not being completed on people's care files to ensure these contained accurate and up to date information about people's needs. For example, one person was being supported by staff with pressure care, however had no skin integrity care plan to guide staff on what support the person needed. This placed the person at risk of receiving inconsistent support which did not meet their needs.
- Staff completed a monthly review of people's care needs however this had not identified where people's needs had changed. For example, reviews on one person's care needs had not identified they had lost weight and explored a potential cause for this. This placed the person at risk of prolonged harm.
- Quality assurance tools had failed to identify where people did not have oral health, end of life, religious and cultural care plans in place.
- Quality assurance tools had failed to identify were people did not have care plans and risk assessments in place for their health and behavioural needs.
- The provider had failed to ensure audits of accidents and incidents were complete and effective to take action to reduce future risk. For example, an audit of accidents and incidents from February to September 2020 stated there had been none. However we found 13 incidents reports completed within this time. This was a continued concern from the previous inspection.
- Quality assurance tools had failed to identify concerns we found during the inspection in relation to people's medicines. For example, multiple people did not have protocols in place where medicines were prescribed on an 'as required' basis.

Effective leadership and quality assurance tools were not in place to ensure people received consistently safe care in line with regulations. This placed people at risk of harm. This was a continued breach of

regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure there was a registered manager at the service since January 2020. Whilst there had been a manager in place, they had not registered with us and the provider had not had sufficient oversight at the service to ensure the service remains compliant with regulations and people consistently received safe care and treatment in line with their needs by trained staff. At this inspection we found multiple breaches of regulations in relation to people's safe care and treatment, staff training, compliance with the MCA, governance and oversight, safeguarding people from abuse and neglect, failure to notify us of safeguarding concerns and failure to have a registered manager in place.

This is a breach of Section 33 of the Health and Social Care Act.

● The provider had failed to notify us where potential safeguarding concerns had occurred within the service, as they had not identified these.
● The provider had failed to notify us of two police incidents at the service, as required by the regulations.

This is a breach of regulation 18 (failure to notify) of the Health and Social Care Act 2008 (Registration) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not documented on accidents and incident reports whether people's relatives had been informed of incidents within the home and was not aware of duty of candour. This meant the provider did not understand or meet the requirements of duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The management team sought feedback from people's relatives through questionnaires. However, where relatives had identified improvements were required to people's care, no actions had been recorded to establish whether these had been made. This was a continued concern from our previous inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● People and their relatives gave positive feedback overall about the provider. One relative told us, "Any concerns I have had [the provider] has got straight onto them and they keep me in the loop."
● The provider acknowledged where improvements were required at the service and took action during and following the inspection to begin making these improvements. The management team were working with external professionals to support them to continue to improve.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure they complied with the MCA.

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 people had care plans and risk assessments in place which reflected their needs and provided staff with clear guidance to support them to meet people's needs. Medicines were not consistently stored safely and people did not consistently have protocols in place where they were prescribed medicines 'as required'. The provider had failed to ensure they were working within government guidance relating to COVID-19. The provider had failed to ensure they had effective oversight of accidents and incidents to reduce the risk of reoccurrence and mitigate continued risks to people.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure they make improvements at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to identify, investigate and report potential safeguarding concerns.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure they make improvements at the service.

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 they had sufficient oversight at the service to identify where improvements were required and embed these into practice. Quality assurance tools were not in place or effective at identifying areas of concern and drive improvements in people's care.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure they make improvements at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure all staff had sufficient and effective training to meet people's needs.

The enforcement action we took:

We imposed conditions on the provider's registration to ensure they make improvements at the service.