Barchester Healthcare Homes Limited

Leonard Lodge

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

Overall summary

The inspection took place on 28 August and 01 September 2015 and it was unannounced.

Leonard Lodge provides accommodation over two floors for up to 60 people who require nursing or personal care. There were 56 people living at the service at the time of our inspection.

The provider's registration required them to have a registered manager in post. An application was being made at the time of our inspection for a new registered manager. 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.

The arrangements at Leonard Lodge were insufficient for managing risks appropriately in relation to people's health and safety. There were risks in and around the environment which needed action to be taken.

Summary of findings

There were not always enough staff with the skills and experience to care for people in a safe way. People were not provided with the care and attention they needed to keep them safe and well at all times.

No formal system of supervision and appraisal was in place, to make sure that people received care from staff who were skilled and confident in their role and responsibilities.

The provider had suitable arrangements in place for the management of medicines and people received their medicines safely.

Staff were recruited safely in line with the requirements of current legislation.

People were not always treated with respect and their dignity, privacy, choices and independence was not always promoted.

Deprivation of Liberty safeguards (DoLs) had been appropriately applied for. These safeguards protected the rights of adults who used the services and who do not have capacity to make their own decisions. Applications had been made appropriately for people who may require them. Appropriate assessment and authorisation by professionals had been completed, for any best interest decision taken regarding any restriction on their freedom and liberty. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice.

Assessments and care files contained all the necessary information about a person's health and social care needs for staff to care for them appropriately.

Care based on risk assessments and information about people's needs, wishes and preferences was not being carried out which meant that people did not receive a service which was consistently responsive to their needs.

A range of quality assurance systems were in place but were not being used effectively to drive improvement to the quality of the service being delivered. Improvement was needed in the areas of governance and leadership of the service to ensure the care and support provided to people was appropriate and was relevant to current best practice and good care.

We found that there were a number of breaches in the Regulations of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

Risks to individuals were not always managed well to ensure people's safety.

Staffing levels were insufficient to meet the needs of people who used the service and keep them safe.

Staff were recruited safely in line with current legislative requirements.

The provider had systems in place to manage people's medicines safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

People did not receive the care and support they needed as staff were not fully aware of their needs.

People did not receive care from staff who were managed effectively.

A system for assessing people's capacity was in place and/or their relatives consent was sought.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were not always treated with dignity and respect and their privacy and independence was not always promoted.

People and/or their relatives were involved in making decisions about their care.

Requires improvement

Is the service responsive?
The service was not responsive to people's needs.

People did not receive personalised care that was responsive to their needs.

People were able to engage in activities of their choice.

Requires improvement

Is the service well-led?
The service was not consistently well led.

The management arrangements did not provide a clear direction and leadership of the service.

The systems for assessing the quality and safety of the service were not effective.

Requires improvement

Leonard Lodge

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 took place on 28 August 2015 and 01 September 2015 and was unannounced. The inspection team consisted of two inspectors.

We reviewed all the information we had available about the service including notifications sent to us by the provider. This is information about important events which the provider is required to send us by law. We also looked at concerns we had received. All of this information helped us to plan what areas to focus our attention on for the inspection. The provider gave us a list of professionals who we could contact to seek their views of the service after the inspection.

During the inspection we spoke with 18 people who lived at the service and nine people's relatives and friends. We received written information from three health and social care professionals about the service.

People who used the service had a range of different needs and ways of communicating their needs. We therefore used informal observations to evaluate people's experiences and help us assess how their needs were being met. We observed how staff interacted with people and with each other. We spoke with the regional operations manager, the clinical service manager and the regional director, and 13 housekeeping, activities, care and nursing staff.

We looked at six people's care records and examined information relating to the management of the service such as recruitment, staff support and training records and quality monitoring audits.

Requires improvement

Is the service safe?

Our findings

Notifications about serious incidents and safeguarding concerns were sent to us, as is required by law and we followed up on two safeguarding issues which we had been made aware of. These had now been resolved satisfactorily. However, we were made aware by a relative of an incident which had put the safety of a person at risk of harm. Whilst, risk assessments had been put in place for the person concerned, the incident had not been followed up and reported appropriately to us at the time of our inspection. We asked the manager to follow this up and inform us of the outcome. The manager provided us with information after the inspection to confirm that an investigation into the incident had taken place and had been resolved.

Family members and friends of people who used the service expressed concern and worry about how safe their relatives were. They made comments such as, "I go home so worried that [relative] won't be looked after." "How many safeguardings do I have to raise to make sure my [relative] is kept safe here." And "I am finding bruising on [relative's] arms and I know they are not taking care getting their clothes on."

We found risks within the environment during our inspection. Relatives made us aware that the locks on two of the three double doors that led out to an enclosed courtyard garden were broken. They said that they had been broken for a while and often benches were put against one of the doors to stop it blowing open. These doors could be opened easily by people using the service day and night allowing them access to the garden without staff knowing. This presented a risk to people's safety, as there was no lighting, different levels of paving, and shrubs and trees which presented as trip hazards.

We showed the clinical services manager the two doors and they told us they were unaware that they had been broken. The maintenance log had an entry for 03 August 2015 which stated that all doors had been inspected and all were functioning correctly.

Since our inspection, the regional operations manager informed us that the doors were alarmed at night from 8pm which meant that staff would be alerted if a person accessed the garden after this time. The managers were unaware of this process and if the alarm was being put on by the night staff when coming on shift.

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

There were insufficient staff on duty to meet people's needs. Before the inspection we had received information of concern regarding the staffing levels and staff skill mix at Leonard Lodge.

Relatives told us that people were being left without assistance and there was not enough staff to give people personal care or support people adequately. One family member said, "There is an over reliance on family carers to deliver basic care to our relatives."

We observed that there were family members and friends visiting the home supporting their relatives during the day. One staff member told us that they would not manage if it wasn't for the relatives visiting. People told us, "Some of the staff know what they are doing, others are agency and don't have a clue." One care staff said, "We just rush about and don't have time to spend with anyone."

We saw one person who was left alone for large periods of the day in the same position without company or any stimulation. We had to intervene when we witnessed one person hitting another person as there were no staff present at the time for us to call. One person was calling out for a staff member to help them back to bed. Their call bell was not within reach to enable them to ring the buzzer for assistance. They told us, "I have been waiting a while." Two relatives had told us people who used the service were not getting personal care as identified and agreed in their care plan because there were not enough staff to do it. We looked at the two care plans this related to and found that one person had only received a bath once during the month with no explanation as to why their assessed needs were not being met.

We asked for copies of the staff rotas for a current four week period to assure ourselves about the staffing levels. We looked at those for 10 August 2015 to 06 September 2015. We found the two separate rotas, one for upstairs and one for downstairs, to be unclear, with gaps in the numbers of staff required to cover the shift and no indication of the use of agency staff to cover those shifts.

The manager told us that they had some members of agency staff who had been with the service for over a year so knew people and how to meet their needs well. However, due to the use of different agency staff and the new recruitment of staff at Leonard Lodge, there was not a

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Is the service safe?

stable staff team that provided people with consistent care, which was based on their assessed needs and routines. One family member said, "I am really worried that my [relative] will be left because they don't have the staff to care for them."

The managers explained that they had recruited new staff recently including registered nurses. The provider had also introduced a new system of assessing staffing levels based on people's needs and occupancy levels in the service which was currently underway, however at the time of this inspection no outcome had been decided on the staffing levels required.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

People who used the service told us they were well looked after and felt safe. One person said, "I am looked after very well and I feel OK with the staff as I can speak up for myself." Another person said, "The staff are kind and they help me when I need it." Another said, "I have my buzzer if I need someone."

The staff we spoke with were able to demonstrate their understanding of abuse and discrimination and describe what they would do if they were told, saw or suspected that someone was being abused or harmed in any way. However, one member of staff could not describe what protection was needed for someone who was being harassed and physically assaulted by another person who used the service. This was raised with the managers during our feedback. The manager completed a safeguarding alert with the local authority in order for this to be investigated and plans were put in place to protect the person concerned.

In the care files we looked at, comprehensive risk assessments were in place, reviews were completed and files updated in order that risks to people's health and safety could be minimised or prevented. People who used the service and their relatives told us that they had been involved in decisions about risks to their health and wellbeing. The risks that had been assessed covered all aspects of people's health and wellbeing and included the management and prevention of falls, people's ability to eat and drink, if they needed the use of a hoist or assistance to move, care of their skin, behaviour issues and personal care.

The incident log recorded when people had falls. For one person, for example, they had seven falls in the month of August 2015. Risk management plans had identified the risks and the manager supplied us with information documenting the intervention and action taken from the advice of relevant health care professionals to aid them in keeping safe.

Safe recruitment processes were in place and were carried out in line with legal requirements. We reviewed three staff personnel files in relation to recruitment process. Each person had a completed application form, provided information relating to any gaps in employment, health declaration, photographic identification, criminal convictions declaration and provided contact information for two references. The provider had obtained the relevant Disclosure and Barring Service (DBS) clearance, carried out interviews and received two satisfactory references before new recruits were allowed to commence employment with the service.

We observed the medicine round on the downstairs floor. We found that the storage, administration and disposal of medicines was undertaken safely and in line with current professional guidelines. One person told us that they got their medicines on time and knew what they were for. Another person said they were offered the choice of having pain relief if they needed it.

We saw that medicine trolleys were securely fixed to the wall when not in use. The contents of the trolleys were well ordered and were clean. There were appropriate facilities to store medicines that required specific storage, for example, controlled drugs and refrigerators for medicines that needed to be stored in controlled temperatures. The medicine storage area was securely locked when not in use and was clean and tidy.

There were records of medicine being received from and returned to the pharmacy. The medicine received, administered and returned to the pharmacy was recorded correctly. We saw that there was a specific cabinet for controlled drugs and the drugs record was completed satisfactorily.

Medicines were given to people in an appropriate way. We observed the nurse carrying out the medicine round and they were competent at administrating people's medicine. They did this in a dignified manner speaking to people about what medicine they were having and supported

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Is the service safe?

them in taking it. We observed the nurse giving a person their medicine. They knelt down beside them and engaged them in conversation for a few minutes and then checked if the person was ready to take their medicine. The medicine round was carried out in a person centred way.

Records relating to medicines were completed accurately and stored securely. People's individual medicines administration record (MAR) sheets had their photograph so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving the wrong medicines. Where medicines were prescribed on an 'as required' basis, clear written instructions were in place for staff to follow. This meant that staff knew when 'as required' medicines should be given and when they should not.

Requires improvement

Is the service effective?

Our findings

Although some staff had the skills and knowledge to meet people's care and health needs and to support them in a respectful way, this was not consistent.

We noted that other people did not always receive the care and support they needed or wanted because some staff were not fully aware of their needs or knew people's individual personalities. One staff member did not know the names of people they were assisting. Another staff member did not know that someone was diabetic and was going to put sugar in their tea until another staff member intervened. One staff member was not able to tell us what plans were in place for someone who needed support around their unpredictable behaviour towards other people.

We observed that some staff did not communicate effectively with people who used the service. Staff told us they did not have any time to spend with people, and one staff member said, "Everything was always a rush," one staff member said. Relatives confirmed that some staff did know people's needs well and felt assured that their family members were being cared for by skilled staff. However, they said their reasons for going to the home so often to care for their relatives was that not all staff were skilled enough and knew their relatives needs well enough to care for them effectively. One relative said, "Another new agency person last week and they didn't have a clue, it's very worrying."

Care plans were in place which correctly identified individual's nutrition and hydration needs. Any identified risks were assessed and recorded and appropriate referrals had been made to GP's, Nutritionists and where appropriate hospital services.

However, staff did not always act on the information provided. We observed one person in the morning and looked at their care plan. We noted that they had an identified risk in relation to weight loss and loss of appetite. Our observation during breakfast was that they were not prompted or assisted to eat or drink. We raised this with the manager and attempts were made to assist them at lunch time. We also noted in the afternoon that the amount of water in their cup was still the same as in the morning. The manager told us that a referral had been made to the dietician and a call to the GP had been made for further investigation.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

Although the clinical services manager told us that they supported the staff on a day to day basis to undertake their role, including access to training, due to the changes in management, there had been no formal system of supervision and appraisal in place for some time.

The clinical services manager told us that a new system of supervision was being put in place as formal one to one supervision had not taken place since 2013 with some staff. A supervision template had been developed for staff to raise any concerns and areas for discussion at their one to one meetings and the manager had only completed three since the development of the new system.

There was an annual appraisal system in place. However, in the three staff files we saw, two staff had not received an appraisal since 2013, and the other was a new staff member. One appraisal consisted of a list of basic nursing duties that the staff member was expected to cover during their shift. There was a management plan in place for them to receive additional training and review their progress. However no review of their performance had taken place. We also noted that disciplinary procedures had not been followed through for a staff member who had received a final written warning in September 2014.

This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

We saw that there was an in-house training programme available for existing staff to do refresher courses on an annual basis. Staff said there is no shortage of training offered. This was provided in both face to face settings and groups and also online whereby staff had to complete this themselves, with a test afterwards to demonstrate what they had learnt. The clinical service manager provided 'in-house training as and when required to develop staff further. Care staff were also offered and encouraged to undertake recognised training such as the Apprenticeship in Health and Social Care Certificate, and nurses employed at the service were registered with the Nursing and Midwifery Council.

Requires improvement

Is the service effective?

The staff told us that there was a good training programme available through the provider, and they had a structured induction programme in preparation for their role. This included training in subjects essential for their role, shadowing experienced staff and spending time getting to know people's needs and ways of meeting them. One staff member said, "My induction has been very good and I feel that I will enjoy working here."

We saw that staff assisted people in an individual way, by talking with them and using their names. For example, we saw staff assisting a person to use a hoist, reassuring another person that they had their favourite trousers on and knowing that one person got upset about their mother not being there and supporting them in an appropriate way.

People we spoke with told us that most of the staff enabled them to keep well, maintain their independence and keep active. One person said, "They [staff] help me do things I can't do." [Staff member] knows how I like my tea and always remembers."

Systems were in place to make sure the rights of people who may lack capacity to make particular decisions were protected and for others, and where appropriate, to make a decision in the person's best interests. The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes.

We saw in people's care files that assessments of people's capacity to make day-to-day decisions had been completed appropriately. The manager knew how to make applications for DoLS and to follow the guidance where people were restricted from leaving the home unaccompanied. We saw that for one person a DoLS was in place appropriately through collaboration with the local authority.

The training programme showed that staff had attended in-house training in the Mental Capacity Act (MCA) 2005, safeguarding adults from abuse and Deprivation of Liberty Safeguards DoLS.

We spoke with two staff that had an understanding of what consent meant, the MCA and how this was applied in practice for people who used the service. However, they did not have a full understanding of the DoLS or the difference between restraint and a deprivation of a person's liberty. Another staff member who supported one person on a one to one basis was not able to tell us the meaning of the MCA or how this related to the person they were supporting.

Most of the staff had an awareness of their responsibilities around assessing people's capacity to make decisions. We saw that staff sought people's consent during care delivery by asking them direct questions and waiting for answers, for example, taking off a person's napkin after lunch and suggesting a change of clothes which they agreed to.

Everyone we spoke with said the food was nice. One person said, "The food is delicious here." Another said, Lovely food can't fault it." We observed people over lunch time. They enjoyed a hot meal, with drinks of juice, wine and sherry available. There was a balanced diet and a sufficient amount for people to eat. People could choose to have lunch in the dining room or in their rooms. People who needed assistance with eating were helped gently and with patience and there was a calm atmosphere during lunchtime in both dining rooms.

The provider had recently introduced a system for protecting the mealtime period so that staff did not go on their breaks during this time. All available staff, including the activity coordinators and hostess staff were available to assist people.

A number of relatives and friends visited the service, some every day and some every other day before lunch and at tea time to assist their family members and friends with their meal. They told us that they visited at that time because there were not enough staff at lunchtime for those people who needed assistance with eating and drinking.

People's day to day health needs were met through on-going assessment and the involvement of people themselves, where possible and their family. Referrals made to health care professionals such as the dietician, tissue viability nurse, chiropodist, optician and GP service were quickly responded to and the treatment and care provided appropriately.

Health professionals we contacted did not have any concerns or issues about Leonard Lodge and said the care provided was, "Satisfactory". However, one health professional told us about a situation where a relative had to raise a concern with the staff when a person was clearly unwell and the staff had not noticed. They said, "I was

Requires improvement

Is the service effective?

concerned that as a nursing home, they didn't seem to have heard any alarm bells for an acute confused elderly person with a reduced appetite and did not, until requested, use a dipstick to test their urine for an infection."

Requires improvement

Is the service caring?

Our findings

During our observations, we saw that most staff interacted appropriately with people who used the service, their relatives, other staff and visitors. They showed kindness and respect and promoted people's dignity. However, we saw times when this was not put into practice.

We noted occasions when staff did not respect people's dignity. One person's bedroom door was left open whilst they were in a state of undress and distress. A staff member attended to them but failed to close the door behind them. This left the person in full view of anyone passing their room. A family member told us of an instance when their relative had been left in the communal area with no underwear on and a transparent blouse. This was considered disrespectful and did not maintain their dignity.

The time that staff spent engaged in a meaningful way with people individually was not always evident unless they were undertaking a task with the person such as giving them a drink, assisting them to go from one place to another, completing personal care tasks and assisting people at mealtimes. Staff told us that they never had any extra time to be with people. One staff member said, "Oh to sit down and really be with someone would be nice."

Some people were assisted by staff who did not talk to them or tell them what they were doing. Staff were often rushing about and went past people without acknowledging them or passing the time of day. They were focussed on doing the task in hand and not about the experience for the person. One person said, "So many new staff, they say hello and that's it."

This is a breach of Regulation 10 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

Some staff knew the social history of people who used the service, their background, what they liked and their preferences. Other staff did not know very much about people who used the service, other than what health needs they had.

People made some comments to us which related to the agency staff which the service used. One person said, "They are OK, but not that friendly at first." Another person said, "Half the staff are nice and half the staff are not so nice." Relatives expressed their concern that new agency staff were being used who did not know people's needs and were being asked to do tasks before getting to know people and their personalities. "One family member said, "It is all just doing things to people rather than having time to be with them."

Most staff communicated well with people, talked directly to them, used eye contact and clear language and helped them make decisions about, for example, what meal to have or where they wanted to spend the afternoon. They were friendly, warm, kind and approachable.

We saw at other times during the day that people's privacy and dignity was respected and promoted by the staff. For example, we saw that staff knocked on people's doors before entering their bedroom and used people's preferred names.

Other people who used the service and their relatives told us that most of the staff were kind and caring and patient. One person said, "Those I know are just wonderful to me, helpful, caring and we get on very well." A relative said, "Most are friendly and kind and have a good attitude to caring. Some of the new ones are nice too .A person's friend said, "[Person] gets on well with everyone. Most are nice and do their job well, those who have been here a while anyway."

People were involved, where possible, in making decisions about their own care so that they could maintain their independence. Relatives told us they were very involved in their family members care and the decisions made about them.

Requires improvement

Is the service responsive?

Our findings

People's care needs were recorded and reviewed on a monthly basis and signed to indicate where and when changes were needed to be made. However, what was happening in practice was not reflected in the recording of people's care arrangements, and their care needs were not always being met as assessed.

Whilst people's wishes and choices were in their care file, we were told by relatives that these were not being carried out. For example relatives told us that they had discussed with the staff about how often their family member wished to have a bath or shower and have their hair washed. It was recorded for one person that they wished to have a bath and hair wash every Wednesday and Sunday. We saw in the daily notes that the person had received a shower once during the month. For another person, they had requested a bath and hair wash every Wednesday and Saturday, but the daily notes recorded that they had only had a hair wash and bath once in July and shower and hair wash once in August 2015.

We observed that some staff failed to recognise and respond to individual's personal needs. For example, when one person appeared unwell at the dining table. This was not recognised or acted upon until we brought it to the attention of staff who subsequently moved them into a comfortable chair away from the table. We saw that during the morning and over lunchtime, the person was left alone for some considerable time. When staff assisted the person to eat and drink there was little engagement or conversation or focus on them and how they might be feeling.

We saw that the care records were developed from the assessment of people's needs when they first went to live at Leonard Lodge. The records contained a photograph of the person and sufficient information about their health and social care needs, preferences and their background history for staff to respond and meet their needs appropriately.

People's mobility needs, pressure care, falls, moving and repositioning, dietary requirements and end of life arrangements were detailed and ways of meeting their needs were recorded.

During the inspection, we spent time observing how staff interacted with people. Staff responded well to people during routine care tasks; such as assisting them to move around the building, putting on their napkin, making them a cup of coffee and giving them their medicine.

For people who could talk with us, they told us that they had been involved in discussing their needs with the staff. One person said, "The staff know me by now as I have been here a while." Another person said, "I have my call bell if I want them."

People could choose whether they wanted a male or female care worker to perform their personal care which gave them dignity and privacy. However, one person told us that on some night shifts, there were two male and one female worker which meant that people might not get a choice.

There were strong close relationships between relatives and people who used the service and relatives visited and supported their family members.

People were encouraged to engage in the group social activities on offer at the service which included in-house activities and visiting entertainers. The service employed two activities coordinators who managed a programme of one to one and group sessions with the staff joining into activities as and when they could. Activities on offer on the days of our inspection included two bingo sessions held upstairs and a music session held downstairs for people to participate in if they wanted to. A meeting with people who used the service to listen to their views also took place as planned. One person said, "They are very kind and help me, [staff member] always has a lovely smile and chats to me."

The management team operated a complaints procedure for recording and responding to concerns. Relatives were aware of the complaints process and knew who to speak to at the service if they had concerns. Relatives had made a number of complaints about the care and wellbeing of their family members which had included safeguarding issues, the skills and knowledge of staff, insufficient staffing and the lack of being listened to by the management. We saw written responses to some of their concerns. Some of these had been investigated and some complaints were still outstanding.

Requires improvement

Is the service well-led?

Our findings

There were systems and processes in operation within the service to monitor the quality of the service provided however these were not effective. The regional operations manager showed us an action plan which covered a range of improvements needed to the service. Audits were completed around all aspects of the service including health and safety. However, some of the records did not match what was happening in practice. They were contradictory of some of the issues that we identified, such as the double doors to the courtyard not functioning properly and people remained at risk of falls even though risk assessments were completed

Another example of this contradiction was that care plans were reviewed monthly and signed to say no changes were required. However, people were not getting the care as assessed for their individual needs and both the managers were not aware of this.

The management of handing over information from one shift to the other was done by giving members of staff handover notes about people's needs. The regional operation manager showed us the handover notes, which were in disarray. They could not establish or confirm which ones showed people's up to date circumstances and needs as some were scribbled over and not dated. This lack of management oversight increased the risks to people's health and safety. Incidents and accidents such as falls and errors were recorded and plans had been put in place to safeguard the individuals concerned but the follow up and learning from them was not evident.

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

The management at Leonard Lodge had been unstable and had changed a number of times during 2015, subsequently resulting in a number of different managers leading the team. The provider had informed us of these changes as they happened. The management team at Leonard Lodge currently consisted of the regional operations manager and clinical services manager with ongoing support and involvement from the provider. A new permanent manager was due to commence employment the day after our inspection.

The managers at Leonard Lodge had responsibility for particular areas of the service, for example, dealing with the management of staff. The arrangements for staffing the service was split between one manager having responsibility for one floor and the other manager the other floor. Managers could not tell us from the rota how many agency staff had filled in duties and what skills and experience they had. From discussion with the managers, it was evident that no one manager had overall oversight or management of staffing throughout the home.

The clinical services manager's role was fragmented and confusing as, in addition to their management duties, they also provided hours working as a nurse 'on the floor' and stepped in with shifts when needed. On the days of our inspection, we were unclear as to what management responsibilities they had and what they were accountable for.

We were told by the managers that due to the recruitment of a number of new care staff and nurses, there had been changes to staffing as well as management. Relatives and staff had told us that this had had an effect on the quality of care that people received. Relatives told us, "There have seemed to have been so many changes to the staff and managers that I don't know who is who these days."

The management roles were unclear and did not provide a clear direction and leadership of the service. This was reflected in comments from the relatives and some staff that we spoke with.

Staff told us that they knew what was expected of them and undertook their role professionally and in a caring way. However, they said they were not well motivated as the lack of staff and the use of agency staff affected the quality of care to people. One staff member said, "We do our best and cover extra shifts where we can. I just hope it gets better."

There were signs up in the lobby actively promoting whistleblowing. However, staff felt that if they raised concerns by whistle blowing there would be repercussions on them and couldn't be assured that their views would be taken on board.

People who used the service and relatives knew the names of the managers. The managers were aware of the day to day culture of the service. They spent time in the service where they were visible and accessible.

Meetings were held regularly with the managers and senior staff to share information about the service and changes to

Requires improvement

Is the service well-led?

individuals' needs and arrangements. Meetings to seek the views of people who used the service took place occasionally and the planned meeting on the day of our inspection was well attended. We saw that relatives' views were sought and complaints and investigations were handled either by the manager or the provider's senior management team. .

Care plans were available to the staff and were put away after use so that they were not left on display. People could be confident that information held by the service about them was kept confidential.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 **Regulation 12** **How the regulation was not being met:** **The registered person had not taken all reasonable steps to ensure the health and safety of people, by doing all that is reasonably practical to mitigate any risks to the individual and within the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(2)(a)** **How the regulation was not being met:** **The registered person did not have suitable arrangements in place in order to ensure that staff received appropriate support, training, professional development and supervision as is necessary to enable them to appropriately perform the duties required of their role.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (1) (2)(a) HSCA (RA) Regulations 2014 Dignity and respect** **How the Regulation was not being met:** **People were not being treated with dignity and respect which ensured the privacy of the service user.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2)(a) HSCA (RA) Regulations 2014 Good governance** How the regulation was not being met: Systems and processes were not established and operated effectively to enable the service to assess, monitor and improve the quality and safety of care provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1)(b)(c) HSCA (RA) Regulations 2014 Person-centred care** How the regulation was not being met: Care was not provided in a person centred way with the preferences of services users taken into account.