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 personal care to a maximum of 33 people. At the time of inspection 18 people were using the service.

People's experience of using this service and what we found

There was a continued lack of understanding, oversight and governance systems to ensure people received a safe service. Systems that were in place were not implemented effectively and audits did not identify ongoing concerns with the service.

Records of care had not been consistently completed. Audits had not identified the gaps in recording found during inspection.

The provider was not complying with a condition of their registration. There was insufficient staff adequately deployed at night time.

People's hydration needs were not always monitored, and timely action was not taken to address concerns where people's fluid intake was low. People were at increased risk of pressure sores because they were not always repositioned in line with the care plan. Injuries or bruising people had sustained had not always been investigated or reviewed.

Infection control procedures required strengthening to manage the risk of cross contamination.

The environment continued to require improvements to decoration and maintenance.

Medicines were safely managed, staff had been safety recruited and completed an induction. People told us they felt safe and the staff supporting them were kind.

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 inadequate (published 29 January 2020) the provider was in breach of regulations 9, 12, 14, 17 and 18.

This service has been in Special Measures since 29 January 2020.

At this inspection enough improvement had not been made/ sustained, and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 10, 11 and 12 December 2019. Breaches of legal requirements were found in relation to person-centred care, meeting peoples nutritional and hydration needs, safe care and treatment, staffing and governance.

Before this inspection we received concerns in relation to documentation recording management of risk. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed following this focused inspection and remains inadequate.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Leys on our website at www.cqc.org.uk.

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 safe care and treatment, staffing and good governance 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
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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Leys 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 have a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager. The provider had employed a manager who was in the process of going through recruitment checks.

Notice of inspection
This inspection was announced 15 minutes in advance.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

We contacted health and social care commissioners who have a responsibility to monitor the care of people at The Leys. We used all of this information to plan our inspection.

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.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with seven members of staff including the compliance officer, area manager, deputy manager, senior carer, the provider and care staff. We reviewed a range of records. This included 11 people's care records and multiple medication records. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, rotas and accident and incident forms.

After the inspection
The provider continued to provide updates to their action plan showing the improvements they were putting into place.

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm

The purpose of this inspection was to check a specific concern we had about recording and people's safety.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure people's risks were being assessed and managed appropriately. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

- People were at risk of skin damage as not all people who had wounds had wound care plans in place. The wound care plan identifies what actions and treatment have been taken and records the evaluation of the wound. Without this, staff would not have the information to establish if the wounds were deteriorating, putting people at risk.
- People who required staff support to be repositioned did not have this support carried out in line with their needs. For example, we found four people had been left for longer than their prescribed amount of time. There was no guidance for staff on the repositioning chart to inform them how often a person required repositioning. When a person had been repositioned the recording of this stated 'rolled', but didn't record in to what position. This increased their risk of skin damage and developing pressure ulcers.
- Accidents and incidents had not been reviewed appropriately to reduce the risk of further incidents. For example; one person fell in their bedroom and stepped over the fall's sensor mat, so staff were not aware they had fallen. Other fall prevention equipment could have been put in place after the incident to reduce any future risks; but no further action had been taken.
- People were at risk of not drinking enough fluids. Where the service had identified the need to record how much fluid a person had consumed, a recording chart was in place. There was no guidance for staff on the chart to assist them in knowing how much fluid each person should have daily. People's fluid charts consistently showed a low fluid intake on consecutive days. There was no monitoring or oversight of the fluid charts to take any remedial action.
- People who were unable to use a call bell to call for help had risk assessments in place for this. However, the risk assessment was generic and did not guide staff on how to ensure the person was safely monitored, taking into consideration any health needs they may have. The risk assessment guided staff to complete a best interest meeting and mental capacity assessment, these had not been completed.

These issues were a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse

● The provider had not investigated the reasons for people's unexplained bruises or skin tears. This meant the cause of the wound had not been identified and measures had not been put in place to reduce the risk of re occurrence.
● Records did not contain sufficient detail about people's injuries, pressure areas or bruising. Body maps did not always contain the relevant information regarding the size or colour of the injury or sore and there was no review of the body maps to monitor the injury. This meant that people were at risk of not receiving the correct treatment for their injury.

These issues were a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

● Staff were knowledgeable about how to report abuse and told us they had access to safeguarding and whistleblowing policies and procedures for guidance.
● People we spoke with indicated they felt safe. One person smiled when we asked if they felt safe.

Staffing and recruitment
At our last inspection the provider had failed to ensure there were sufficient numbers of care staff deployed to meet peoples assessed care and support needs. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvement and was still in breach of regulations.
● There were not enough staff deployed to meet people's needs. At the previous inspection in December 2019, we identified there was insufficient staff deployed, in particular, on night shifts. As part of the enforcement action taken from the previous inspection, it was made a condition of the providers registration to ensure three staff were deployed between 19:00 and 07:00. Three staff were not deployed at night at the time of our inspection.
● The provider informed us they had three members of staff work at night, but then reduced the number of night staff to two, when occupancy levels in the home reduced. However, the provider failed to recognise the risk to people remained the same.
● Five people required two staff to support them with personal care needs during the night. During this time, there was no other staff in communal areas of the building to support people if they required it.

Systems were either not in place or robust enough to demonstrate staffing levels were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place, which were consistently followed.

Preventing and controlling infection
At our last inspection the provider had failed to ensure that procedures relating to infection control had been followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvement and was still in breach of regulations.
● Some areas of the home were not clean or maintained in a way to mitigate infection risks. The laundry room was cluttered, disorganised and had a dirty sink. An en-suite recorded as having been 'deep cleaned' had a dirty toilet and a fluid spillage was clearly visible on the wall.
● A soiled pillow was left on top of a laundry trolley in the corridor leading to the laundry room which was unlocked. Used bed linen and towels were mixed together with an apron that people wore to protect their

clothes when eating. An empty bedroom which was used to store clean laundry was very untidy, people's clothes were mixed together, and unclean laundry was also stored in the same room.
● Food hygiene procedures were not consistently followed. We saw catering staff working in the kitchen without suitable personal protective clothing.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had relocated the laundry room since the previous inspection and new flooring had been fitted in parts of the building. This had a positive impact on infection control and the environment.

Learning lessons when things go wrong
● Lessons had not always been learnt from the previous inspection and there continued to be a lack of oversight.
● The provider made immediate changes to the staffing rota when we spoke to them about our concerns with the levels of staffing at night.
● Immediate action was taken when we spoke to the provider about the lack of action that had been taken following accidents and incidents.
● Immediate action was taken when we spoke to the provider about the condition of the laundry room.

Using medicines safely
● Medicines systems were organised, and people were receiving their medicines as prescribed. People's medicines were stored safely, and processes were in place for the ordering and supply of medicines. Staff completed people's Medication Administration Records, to confirm people had taken their medicine.
● Regular medicines audits were carried out to ensure that any concerns were promptly identified.

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 Inadequate. At this inspection this key question has remained the same. 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.

The purpose of this inspection was to check a specific concern we had about recording and people's safety.

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.

At our last inspection 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 not made enough improvement and was still in breach of regulations.

● The service did not have a registered manager in post; however, a manager was in the process of being recruited and was undergoing recruitment checks. The previous registered manager had made improvements to the service, however there were still areas of risk which placed people at risk of harm.
● We found continued issues with management oversight, records and monitoring of risk. These were all identified at the previous inspection. Limited improvements had been made in these areas.
● The provider was not complying with a condition on their registration. Namely, three staff will be on shift between the hours of 19:00 and 07:00.
● Audits had not identified issues relating to gaps in recording for repositioning checks and gaps in fluid monitoring charts. The provider did not identify where care standards had failed and had not put actions in place to reduce risks to people.
● People were at risk of receiving unsafe care due to the lack of oversight of the service and records. For example, accident and incident records were not reviewed thoroughly enough and the appropriate action taken, weights recorded for people were inconsistent and people with skin tears did not have wound care plans in place.
● Staff did not have all the information they required to provide safe care. The provider did not have systems in place to make sure all risks had been assessed, monitored and mitigated. Care records did not always contain enough information to ensure staff could support people appropriately. For example, it had been identified a person was at increased risk of falls at a certain time of day and required closer observation. There were conflicting times the person should be observed from, it was not clear how staff were to observe the person and no recording chart in place for observations.
● Staff did not follow people's plans of care. For example, people who required targeted fluid amounts due to potential health issues and people who required repositioning every two to three hours did not always

have this need met. People continued to be at risk from potential harm.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

● The provider had implemented new quality assurance systems and processes since the previous inspection. However, these were monitored remotely due to the covid-19 pandemic which led to false assurances the manager in post had oversight of the service.
● Care plans had been re-written since the previous inspection and they contained information that was up to date and person centred.

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. Continuous learning and improving care.

At our last inspection 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 not made enough improvement and was still in breach of regulations.

● The provider's systems and processes failed to identify incidents when things went wrong which meant they had not always exercised their responsibility under duty of candour. For example, the provider did not conduct investigations for safeguarding incidents such as unexplained bruising and skin tears.
● Where systems and processes had identified the need for improvement this had not consistently been actioned or used for the purpose of driving the quality in the service and achieving good outcomes for people. For example, a 'you said, we did' board was in use for the provider to inform people what had been improved in response to feedback. This was in place but contained no information. The action plan told us a laundry assistant had been employed. This was not in place.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others
● Staff told us the provider was visible throughout the service and was open to feedback and suggestions.
● Staff felt fully supported by the provider and felt able to raise any concerns. Staff told us they felt the provider would action any concerns they raised immediately.