Leaf Care Services Ltd

Ixworth Dementia Village

Inspection report

Ixworth Court
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ixworth Dementia Village is a residential care home providing accommodation and personal care for up to 24 people. At the time of our inspection there were 12 people using the service most of whom were living with varying levels of dementia. The service consists of three houses (Mayfair, Homely and Traditional) which are all on the ground floor. At the time of the inspection, due to occupancy, only two of the houses were open and in use.

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

Since our last inspection the service had received continued and enhanced support and guidance from the Local Authority. Despite this the provider's management systems were repeatedly failing to identify concerns and support improvements. This is the third consecutive inspection where the provider has been rated inadequate and there have been multiple breaches of the regulations.

Care plans did not accurately reflect people's needs and they lacked guidance for staff about how to support people's individual high risk healthcare needs. People were placed at risk of malnutrition and dehydration. We were concerned that people were not safe. We made 3 safeguarding referrals to the local authority during this inspection.

Medicines were not safely managed. Records did not reflect that topical creams and ointments were administered in line with the prescriber's instructions.

There were insufficient numbers of staff available to meet people's needs in a person centred and timely way. The provider took action to increase the staffing levels during the day immediately after our inspection. They did not increase the staffing levels overnight, however. Staff recruitment systems were in place to ensure only suitable staff were employed.

People did not always receive care which was respectful or dignified. People were wearing clothes that were visibly written on in order to identify their laundry. Some of the language used in care plans was disrespectful to people. Some staff were not patient and kind with people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Decisions were not always made in people's best interests.

Duty of candour was not complied with. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. We found the registered manager and provider were not open and transparent. Care records were amended retrospectively. A person living at the care home did not have an accurate reflection of their needs

relayed to their family. The provider had not always notified CQC of incidents or accidents which is a requirement of their registration.

The provider failed to develop effective governance and quality assurance systems to assess the quality and safety of the support people received. There was limited oversight of the day-to-day operation of the home and the actions of the registered manager. The lack of effective provider level audits failed to determine trends and themes.

There were systems in place to protect against the spread of infection.

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

Rating at last inspection and update
The last rating for this service was inadequate (report published on 3 November 2022) and there were breaches of regulations.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service. We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to dignity and respect, safe care and treatment, good governance and duty of candour.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Special Measures
The overall rating for this service is 'Inadequate' and the service 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Ixworth Dementia Village

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection site visit was completed by two inspectors on both days.

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

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 6 May 2023 and ended on 17 May 2023 when feedback was provided to the Nominated Individual and one of the directors of the provider company. We visited the service location on 6

and 10 May 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who lived at Ixworth Dementia Village to seek their views of their care and support. Not everyone who used the service were able to tell us about their experience of receiving the service, so observations of care and support were also made. We had contact with 5 people's relatives and spoke with 16 staff members. These included the directors of the provider company, the nominated individual for the provider (the nominated individual is responsible for supervising the management of the service on behalf of the provider), the registered manager, the deputy manager, care manager, the chef and 9 other staff.

A selection of records was also viewed, and these included the care plans and associated records for 7 people who used the service. The medicines records for 9 people were also assessed. The governance records viewed included policies and procedures, staff recruitment records, training information, quality monitoring audits and maintenance records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last 2 inspections the provider had failed to ensure risks had been fully identified, managed and mitigated. This was a repeated breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider remained in breach of Regulation 12.

- Risks in relation to people's support needs during periods of anxiety or distress were still not being effectively mitigated. Staff had not been provided with sufficient guidance on how to support people when they became upset or anxious. Some care staff responses to people who were distressed was not always appropriate.
- Staff were not permitted to contact emergency services or healthcare professionals without the permission of the registered manager, even if they were not at work. This delayed the seeking of help for people when they were unwell and placed them at risk of significant harm.
- One person had a significant medical condition, however there was no information in the person's care plan about risks around the medical condition, what the signs and symptoms of a deterioration in the person's health were, and what staff should do to support the person. Failure to document these risks placed the person at increased risk of harm.
- Another person had a heart condition and a pacemaker fitted. There was no care plan in place to guide staff on safety precautions they needed to take as well as signs that would indicate the person had developed an infection or needed medical assistance.
- One person had epilepsy, there was no care plan to highlight the risks or to guide staff in how to care for the person in the event of them having a seizure
- Risk assessments and care plans were not followed accurately. For example, some people were cared for in bed, however, their care plans contained insufficient detail to ensure they maintained their skin integrity. Records did not evidence that people were supported to change their position, in line with best practice, to prevent pressure ulcers developing.
- Where fluid charts were in place, these did not show people had been offered sufficient to drink. For example, 1 person had a target of 971mls to drink each day, records over 6 days showed they had drunk under 100mls a day on 2 days and under 200mls a day on 2 days. The final 2 days showed they had only drunk around 350mls. This meant people were at risk of dehydration.
- We were concerned that several people had unintentionally lost weight during 2023 and despite this, the provider was not actively monitoring people's nutritional intake. For example, one person had lost 8kg of

weight and another person 6.6kg between January and April 2023. Records did not evidence fortification of foods, additional snacks or milky drinks being offered to support people to sustain or gain weight.
● During the first day of our inspection, we observed that people were offered lunch at 12 noon. This was followed by tea of soup and sandwiches at 4.30pm. Following this people were only provided with 2 biscuits each at 7.30pm. This meant people had in the region of 16 hours before they ate again at breakfast the following day. One person's relative told us, "They have lunch at 12 noon but dinner at 4:30pm. They told me they would move this to later as its far too early, a long time before breakfast. [Family member] would never have eaten that early."
At this inspection we found continued concerns about the management of risk and the provider remains in breach of Regulation 12.

Using medicines safely
At our last 2 inspections the provider had failed to ensure medicines were safely managed. This was a repeated breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found continued concerns and the provider remains in breach of Regulation 12.

● When people were prescribed medicines on a when required basis (PRN) we found some continued discrepancies.
● On the first day of inspection we found records relating to the administration of topical medicines (TMARs) were still not always being completed to show that items such as creams and ointments had been applied to people when required. 4 days later on the second day of inspection we found these records had been completed retrospectively. This meant there was a falsification of medicines records.
● One person did not have their topical pain-relieving gel administered in line with the prescribers' instructions. This meant they were at risk of being in pain.
● We found medicines errors were still not being promptly identified and resolved.

The shortfalls we found in the management of risk and medicines demonstrated a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems and processes were not robust to ensure people were always protected from the risk of abuse.
● People were not always safe, appropriate action was not always taken to keep people protected from the risk of abuse and harm.
● During this inspection we made 3 safeguarding referrals to the local authority due to the concerns we found and in order to keep people safe.

Staffing and recruitment
At our last inspection we recommended that the provider continued to closely monitor and review staffing levels using an effective tool and through communication with people using the service, relatives and staff to ensure people's needs continued to be met in a timely manner.

● At this inspection we had continued concerns about the staffing levels. There were insufficient staff to ensure people's needs were met safely. We considered the number of people who required two staff to assist with their personal care and the staff left available to support other people including those who were distressed at times.
● Immediately following our inspection, the provider told us they had increased the staffing levels each day

between 7am and 10pm.
● The staff files we viewed evidenced that staff were recruited safely, and that Disclosure and Barring Service (DBS) checks were carried out on staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
At our last inspection we found improvements were required to ensure the risk of infection was reduced.

At this inspection we found improvements had been made. All rooms had hand washing facilities and paper towels. Overall, the environment was cleaner.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Relatives told us they were able to visit freely.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection we identified that further development was needed to ensure consistency of approach of the Mental Capacity Act.

- We were not assured that people's best interests were at the heart of decision making.
- People were not supported to have maximum choice and control over their lives. There were restrictions in place such as locked doors into the enclosed garden. Many people were living with advanced dementia and could not ask staff to open the locked doors to enable them to access the garden. Best practice in dementia care advises that access to a garden offers fresh air, exercise and exposure to sunlight which is vital for wellbeing.
- Applications to deprive people of their liberty had been made appropriately and any conditions complied with.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection we made a recommendation that the provider carried out their own mealtime experience audits to identify areas of good practice and whether further learning was needed to ensure a pleasant and well organised meal for people.

● We noticed that there was no fresh fruit or snacks available for people. This was important as many people were living with advanced dementia and did not always stop to eat a main meal. We queried the lack of availability of fresh fruit and snacks with the registered manager and were told, "We don't have it because people might throw the apples". They later told us this was because the provider was concerned about waste and the financial implications.
● We noted improvements to the meal time experience. People ate in the smaller dining areas and the chef brought meals to them in a large trolley. The chef asked people what they would like, and choices were offered at the point of service.
Adapting service, design, decoration to meet people's needs
● At our last inspection we found the environment continued to need improvement to ensure that good practice guidance in dementia care was being followed. At this inspection we found whilst there were some improvements, and there had been redecoration, further work was needed.
● Improvements were required to ensure the environment was fully dementia friendly. Whilst signage, to help people navigate around their home had been introduced, this was the same colour as the walls and wasn't clear. Best practice guidance in the support of people living with dementia confirms the environment can have a significant impact on the person living with dementia and that the use of colour and contrast can be really helpful.
● Whilst rooms had been identified with signage, these were of tree names and not the person's name which did not support them with orientation within their home.
● The garden remained a sparce area with many weeds and little planting. We raised this with the registered manager during the first day of our inspection. During the second day some plants were being added.
● People's bedrooms were personalised with photos and items important to them.
● A former lounge had been converted to an activities room so people could be involved.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Referrals to external medical professionals were not always made in a timely manner to ensure people received additional support when required. During the inspection we observed someone expressing pan and no medical assistance was sought for them until the inspection team requested it.
● Healthcare professional advice was also not accurately implemented to ensure the best outcomes for people.
● The provider had not completed any new assessments since the last inspection as there had been no new admissions into the home.

Staff support: induction, training, skills and experience
● Staff continued to have differing opinions about the level of support provided to them. Some staff described the registered manager's approach as controlling and they were fearful of having work hours reduced if they raised concerns.
● New staff had an induction and completed shadow shifts before working on their own.
●The training matrix showed staff training was now being kept up to date.
● Staff competency assessments were completed in a variety of areas to assess the knowledge and working practices and to ensure staff were working to the required standards.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

At our last 2 inspections we have found people were not always treated with dignity and respect. This was a breaches of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection we found improvements had not been made and the provider remained in breach of Regulation 10.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People continued to not be engaged and stimulated. At this inspection we observed people left unsupervised for long periods of time with no meaningful activities in place. This was in particular relation to people who were cared for in bed. One person told us, "I'd love it if the [care staff] came to talk to me more often, I get lonely. "
- Staff did not always provide personalised support and kind reassurance. During our visits some staff did not respond appropriately when people appeared distressed. We observed abrupt reactions and a lack of empathy.
- People had their room number written in black pen on their clothing including their socks. This was clearly visible and not respectful of people's dignity.
- Staff did not always treat people with kindness, nor in a caring way. We observed a staff supporting a person to eat a yoghurt with no communication at all. We saw staff assisting a person with repositioning using the hoist with no communication or reassurance provided.
- We found a lack of response to people expressing pain, and systems for pain management not effective. One person verbalised pain but was not offered pain relief. Where people had PRN (as required) pain relief, staff did not check with them routinely to see if they required this. This was especially important as many people may not have asked for it. There was a lack of pain management records to guide staff in how to recognise when people were unable to verbally express they were in pain.
- People were not supported in a respectful manner. Records did not support the provision of oral hygiene being provided.
- Language used in people's care plans was not always enabling and dignified.
- Some people had signs of poor nail care, their nails were ragged and dirty.
- The provider did not support people's autonomy and independence. Staff restricted people from having free access to the garden despite it being secure.

People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider continued to fail to have a quality assurance system in place that ensured a safe and caring service was delivered; the duty of candour requirement had not been met. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we found continued serious concerns and the provider remained in breach of the regulations.

● There have been systemic failings at provider level. Over the 3 inspections within the past year, we have raised extensive concerns. The provider has repeatedly failed to ensure people received a well-managed service which was safe. The history demonstrates that this is not a service or provider that is continually learning, developing, and improving the care for the vulnerable service users to which it has a duty of care.
● Relatives were not all complimentary about the registered manager or provider. One relative told us, "I think the care has gone downhill even more since the new manager came in." Another relative said, "I am not sure [registered manager] is that knowledgeable." A third relative commented, "Sometimes they are overly concerned with paperwork rather than empathy towards people [who live at the care home]."
● The provider's systems and processes had not enabled the registered person to identify where quality and safety were being compromised as reported in the safe domain of this report
● Records relating to the care and treatment of people were not always reliable and fit for purpose. People were placed at risk of harm as their records were not consistently accurate and detailed and important care plans were not in place.
● There was a culture of reliance of stakeholders and CQC to identify concerns in order that the provider could take action. The significant concerns we have identified throughout this inspection had not been independently identified and acted upon by the management team through their own oversight and quality assurance system.

The provider failed to assess, monitor and improve the quality and safety of the service. This was a repeat breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
● We had continued concerns about the honesty and transparency of the management team. We were made aware of care records being amended and retrospectively completed and attempts to persuade staff to be untruthful to the inspection team. This meant we were not assured the provider and registered manager were being open and transparent with us at all times.
● Complaints were not always managed in line with duty of candour. Actions by the registered manager were not always transparent.
● The registered manager had not always submitted CQC notifications about incidents as they are required to do by law to CQC. We identified a safeguarding concern had occurred that we had not been notified of. The providers lack of oversight meant this had not been identified.

The provider failed to comply with duty of candour regulations. This was a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The provider did not always work in partnership with stakeholders. Advice was misinterpreted and not relayed accurately to relatives or health and care professionals to monitor and meet people's needs.
● Despite extensive input and support from the Local Authority Contracts Team and Local Authority Safeguarding Team the service had not made the necessary improvements.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

The enforcement action we took:

Notice of Decision to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have systems in place to ensure risks to people were appropriately assessed, reviewed or actioned, placing people at risk of unsafe care and treatment

The enforcement action we took:

Notice of Decision to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's continued lack of oversight and effective systems placed people at risk of receiving unsafe care.

The enforcement action we took:

Notice of Decision to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider was mot open and transparent and failed to comply with duty of candour regulations.

The enforcement action we took:

Notice of Decision to cancel the location