Leaf Care Services Ltd

Leaf Park Dementia Village

Inspection report

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

Summary of findings

Overall summary

About the service
Leaf Park Dementia Village is a residential care home providing accommodation and personal care for up to 19 people. At the time of our inspection there were 19 people using the service all of whom were living with varying levels of dementia. The service consists of two units, one on the ground floor (Urban) and one on the first floor (Homely), each of which has separate adapted facilities. There was also accessible outside space, and communal areas where people could spend time together.

People's experience of using this service and what we found
Risks to people were not always assessed and managed in a way which ensured people's safety. Actions had not always been taken to minimise risks. This put people at risk of injury or their health deteriorating.

There were risks in the environment which had not been addressed by the provider. This included items that people could accidently ingest. Infection control procedures needed to be more robust to ensure the service was clean and hygienic. Medicines were not always being managed safely at the home.

There were not enough staff deployed at the service which put people at risk. The service had not effectively assessed the dependency needs of people so they could calculate accurate staffing levels. Staff had not received some training relevant to their role to ensure good practice within the service.

People we spoke with were accepting of the service provided to them. People told us the staff were kind when interacting with them, but sometimes the staff member supporting them would be called away because other people's needs were more urgent. People's privacy and dignity was not always considered.

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. The principles of the Mental Capacity Act were not properly understood by the staff or management team.

People's nutritional and hydration needs were not appropriately managed and this placed them at risk of harm. The quality of food provided was poor at times and choices were limited or not promoted to people. The serving of meals to people did not ensure they were hot and appetising and hygiene standards needed improvement.

People were not always referred in a timely manner to specialist professionals such as dieticians. Relatives gave us examples of when they had to prompt the service to seek professional advice.

Evidence based guidance was not being utilised to enhance people's experiences when living with dementia. The provider had not designed and decorated the premises in a way that supports people living with dementia.

Each person had a care plan in place but there was not always sufficient detail to guide staff. Some areas of people's care hadn't been planned to reduce risk. We were not assured that the provision of activity was meeting people's individual and specialist needs.

There was a complaints procedure in place. Relatives felt able to raise issues, but they were not always confident changes would be made as a result.

The provider's auditing systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving safe care as risks had not always been mitigated. This placed people at continued risk of harm.

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

Rating at last inspection
This service was registered with us on 22 October 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the quality of people's care, including people's safety, their dietary intake, and environmental concerns. A decision was made for us to inspect and examine those risks.

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, responsive and well-led sections of this full report.

Following the inspection, the provider took steps to mitigate risks, such as ensuring the environment was safe by locking away chemicals and creams, arranging training sessions for staff, and had begun updating care plans to ensure people's needs were clearly documented. They had also referred people to external professionals for their advice.

The overall rating for the service is Inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, medicines, consent procedures, staffing, nutrition, person-centred care, and 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
We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will also request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

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

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Leaf Park 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
This inspection was carried out by three inspectors, one of whom specialised in medicines. There were two Experts by Experience who spoke with people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Leaf Park 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. Leaf Park 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 who we were told attended the service twice a week. There was also a manager in post who was in charge of the day to day running of the service. They had recently applied to be the new registered manager. We will refer to them as the, "Manager" in this report.

The nominated individual was present on the day we inspected. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced.

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

We used all this information to plan our inspection.

During the inspection
We reviewed two care plans and 10 medicine administration records, and spoke with three members of staff about medicines. We also spoke with three members of care staff, the cook, the nominated individual, the manager, and a business support manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We reviewed a further three care plans and associated records.

We spoke with eight relatives and four care staff.

We spoke with the local authority Quality Monitoring Officer, the district nurse locality lead, and the community nursing sister.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks relating to people's care were not always sufficiently detailed or managed. Where people had specific health conditions such as diabetes or mental health needs, more detail was required to ensure staff had guidance on how to mitigate risk as far as possible. This also related to risks such as choking and falls. Not having the correct guidance placed people at increased risk of harm.
- We found one person was eating the incorrect consistency of food placing them at risk of choking. On one occasion their daily notes stated that they had started to choke, and that the person should have a liquid diet. Staff did not follow this and the person continued to have foods which were not suitable for them. We made a safeguarding referral to the local authority in response to this.
- The service had not identified that one person who was a diabetic was eating high sugar foods. This placed the person at risk of their blood sugars becoming too high. There was no diabetes risk assessment in place.
- We found items accessible to people living with dementia which could cause them harm. This included a drinks thickener which could cause suffocation if accidently ingested. Chemicals such as cleaning sprays and bleach tablets were also not securely stored. This meant people could access them and put themselves at risk of accidental harm.
- Items that could be used as a weapon, for example, heavy glass ornaments, were accessible to people in the dining area. Consideration had not been given as to whether these posed a risk to people.
- Medicines prescribed for external application such as creams and emollients were not being kept safe to ensure people could not access them and put themselves at risk of accidental harm.
- Whilst there were medicine checks in place, medicine errors were not being properly reported, collated and overseen in a way that led to improvements.
- Some people who were unable to consent to taking their medicines and would otherwise refuse them were deemed to be able to have their medicines given to them concealed in food or drink (covertly). However, we found that for one person the service had not yet reached and recorded a best interest decision about this and by consulting with appropriate healthcare professionals.
- For a person prescribed medicated skin patches there was a lack of records about the removal of previous patches needed for safety. In addition, records were unclear about the sites of application of the patches to the person's body to ensure there had been appropriate intervals of time before repeating the site of application to avoid the potential for irritant skin reactions.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Fire doors were suitable for the purpose for which they were being used, however, we found one fire door

to be propped open.
● At the front entrance was a locked box which held information that in the event of a fire, the fire service would need to access. The manager told us the key to this box was held by two staff members, neither of which were on-site. This placed people at risk of harm as the fire service would not be able to retrieve the information they needed to safely evacuate the building. We were later advised that a key was kept in the office to open the fire box, however, the manager wasn't aware of this at the time of asking.
● Checks for fire safety equipment were in place. There were checks in place to reduce the risks of legionella bacteria in the water system.

Staffing and recruitment
● There were insufficient staff deployed to ensure people received their care in a timely manner and that their safety was monitored. Between 1am and 7am, there were only two staff on duty. The layout of the building further impacted on staff's ability to respond promptly as the units were on two floors. The nominated individual told us that their dependency tool (used to calculate staffing levels) had not been effective and had not taken into account people's dependency needs.
● On occasions during the night one unit was left unmanned due to one staff member having to assist the other to reposition people on a different floor. This placed people at risk of harm as there was no one to monitor their welfare. Following the inspection the provider increased the night shift to include a third staff member until 4am. However, this still left a gap of two hours from 4am to 6am when only two staff were on duty.
● Staff members told us staffing at night was of particular concern. One staff member said, "We have been asking for a third [staff member] on nights for a while. If [person] is agitated we can't leave the unit, so people have to wait if they need support. It's not ideal. At some point during the night one unit will be [unmanned]. How long for depends on what help is needed. It can be 10 minutes or longer if someone is unwell."
● We could not be assured that staff received training relevant to their role as there was not a training matrix in place which the service could monitor effectively. There were, 'Drop in' training sessions which staff could attend but these were optional. One staff member wasn't aware of these sessions. Three staff we spoke with told us they had not received training in end of life care, first aid, or the Mental Capacity Act 2005.

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

● Following the inspection the nominated individual arranged additional training sessions and has set relevant training courses as mandatory for all staff.
● Staff were recruited safely, which included Disclosure and Barring Service (DBS) checks. (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
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found some areas of the service to be unclean, such as two toilets which were heavily soiled. Both clinical waste bins were overfilled. Some toilets did not have either soap or a waste bin, and some had rusty handrails which cannot be cleaned effectively. Some areas in the upstairs kitchen were unclean.

● We were somewhat assured that the provider was admitting people safely to the service. People were tested prior to admission into the service. However, risk assessments relating to COVID-19 were not in place

to identify who may be at higher risk due to certain medical conditions. Guidance states that a risk assessment should be conducted to determine whether the incoming person should isolate. This had not been completed.

This was a further breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives we spoke with told us they were able to visit their relatives, and that the systems in place were now more flexible than previously. However, service policies such as indoor visiting and visits out of the care home did not reflect current Government guidance and required updating.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Systems and processes to safeguard people from the risk of abuse
● Information provided to us by the local authority informed us of one current alleged safeguarding incident under investigation.
● Staff had not always recognised when incidents that occurred were of a safeguarding nature and reportable. One staff told us they had not received safeguarding training recently and they needed a refresher. One staff member told us, "I've had online safeguarding training, but I learn better face to face. Some training where we can have discussions would be better."
● The registered manager had notified the local authority of incidents which would require a safeguarding referral however, they had not always notified CQC of these, which is required by law.

Learning lessons when things go wrong
● The provider had failed to ensure lessons were learnt and advice was followed; the local authority Quality Monitoring Officer had visited in October and November 2021, and during these visits the risks associated with people accidently ingesting unsecured items such as topical creams and cleaning chemicals was discussed. They visited again in March 2022 and advised that they need to ensure these are secured. However, we found that this remained an issue and no action had been taken to reduce the potential risk.
● Accidents and incidents were logged. However, trends were not always identified month on month to mitigate the chance of recurrence. Audits had failed to identify issues that were an obvious risk to people's safety.
● Relatives told us that they did not think that lessons were always learnt. Three relatives told us of concerns about the laundry arrangements which continued to occur.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not always receiving food in line with their assessed needs. Where care plans stated that people should receive a healthy balanced diet containing lots of fresh fruit and vegetables, food charts did not always evidence this was being adhered to.
- Staff did not always ensure that people were offered nutritious food; snacks mainly consisted of cakes and biscuits, rather than healthier options such as nuts or fruits.
- One person was eating the incorrect consistency of food, despite the care plan outlining their needs. This put them at risk of choking.
- People's nutritional needs were not regularly reviewed to ensure people were receiving appropriate nutrition. This included where people lacked capacity to choose a healthy diet. One person who had diabetes, consistently ate cakes and biscuits but their capacity to make this decision hadn't been assessed.
- During the lunchtime meal, we observed that people were offered limited choice. On both units, there was one choice of lunch. We observed two people who didn't want the hot meal and both were given sandwiches, with no alternative hot food offered. On one unit, all five people had the same portion size. This did not demonstrate a person centred approach where individual choice was offered.
- The chef was not aware of people's dietary needs, including who was diabetic.
- We could not be assured that food was served and maintained at the right temperature for the whole mealtime. Meals were seen to uncovered when being transported from the kitchen to the units.

This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- In response to our feedback, the nominated individual made referrals to the dietician and diabetic nurse. They also ensured the cook was aware of people's dietary needs.

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.

● There were two authorised DoLS in place. When we asked the nominated individual and manager if there were any associated conditions or recommendations, they advised us that there were not. However, we found this was not the case. Conditions and recommendations included assessing a choking risk, an MCA assessment for a sensor mat, COVID testing, and a monthly review of covert meds, including an update of peoples care plans. Due to the failure of these not being checked, delays had occurred in meeting the conditions and recommendations which placed people at risk of harm.
● MCA assessments were not always in place for DoLS applications, or mechanical restraints, for example, sensors mats which are used to monitor people's movements.
● One MCA assessment which was in place did not reflect the guidance that the best interest assessor had recommended.
● MCA and best interest decisions were not in place for three people who ate unhealthy food to ascertain if they had the mental capacity to make unwise decisions if this was their choice.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service had not always referred people to specialist services and professionals in a timely manner to ensure their care and treatment was effective.
● Two relatives told us they had raised health concerns with the service about their relatives, and only then did they take action. There was a concern that issues were not being identified by the service independently.

● People's needs were not always holistically assessed. For example, where people experienced periods of distress or health issues such as diabetes, there was not always sufficient guidance in place to prevent the risks as far as possible.
● Pre-admission assessments were limited in detail, and not all questions were answered.
● The service had not ensured guidance was being followed, for example, with people's dietary needs. There were delays in referring people for advice from a dietician.
● The Mental Capacity Act 2005 was not fully understood by staff, and people's care was negatively impacted as a result. People were not given as much opportunity as possible to make decisions about their care.
● Best practice guidance was not always referred to or used to increase the effectiveness of people's care. This included best practice guidance for people living with dementia and relating to specific health conditions such as diabetes.

Staff support: induction, training, skills and experience
● Staff were required to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● Staff received an induction and shadowed more experienced staff before they worked independently. Staff told us they received regular supervision, including observed practice. However, several staff told us the on-going training was variable. One staff member said, "I haven't had first aid training or Mental capacity training. I know a bit because of my last job, but I'd like more practical face to face training. A relative told us, "There seems to be a very inexperienced team in there. I am not sure that the staff have the training to deal with some of [relatives] behaviours. The residents there seem to be very much left to their own devices.''

● We were not assured that staff had the appropriate skills and competency to support people with behaviour linked to anxiety, distress or other factors. Although the training matrix showed staff had training in this area staff did not always appear competent in supporting people who might exhibit distress and frustration in a manner that posed risks to others.

Adapting service, design, decoration to meet people's needs

● Improvements were required to ensure that good practice in dementia care was being followed, such as designing and decorating premises in a way that supports people. For example, doors, seats, and handrails being in a contrasting colour.

● The service was mostly painted in white which did not assist people to navigate independently around the service and can cause confusion. This demonstrates a lack of knowledge in relation to best practice guidance for people living with dementia or a visual impairment.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence

- Due to the systemic failings outlined in this report, people living at the service did not always benefit from a caring culture.
- People did not always appear well presented; we noted some people wore clothes than had not been ironed. One person had heavily chipped nail varnish and their hair was not brushed. We observed that some bedrooms were not tidy, and in some cases, clothes were stuffed in a draw with no order to assist people living with dementia.
- People's dignity was not always considered. One bathroom was stacked with continence pads, rather than storing these discreetly.
- Care plans were not person centred. They did not explore people's preferences in how they liked to look, what they liked to wear, or more personal aspects such as if the person liked to wear make-up or use perfume or aftershave.
- People's care plans made reference to tasks people could do for themselves, however, we did not always see this happen in practice. For example, one care plan stated that the person can eat independently if the food is cut up into bite sized pieces. However, we saw this person being fed by a staff member whilst the person was lying in bed.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People told us that staff were kind and caring when interacting with them. However, we observed staff to be unsure at times whether to interact with people or not. When one person was becoming agitated, staff watched them rather than providing a distraction, or starting a conversation.
- People were asked a series of questions during a monthly check of their care plans. However, we could not be assured that all people were given the same opportunities; one comment stated, "Due to [person's] dementia diagnosis they are unable to answer the questions". The service had not considered other options available for seeking feedback such as from family members or the care staff involved in the person's care.
- The issues we identified in other areas of this report in relation to assessing people's mental capacity, does not show that people are given every opportunity to make decisions, even if they are unwise ones.
- Care plans referred to people's life histories and what people enjoyed doing. However, this was often limited in detail. Having more detail will help staff to engage in conversations in a more meaningful way.
- People's sexual health needs and relationships were not considered or explored.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support

● There was not always sufficient and up to date guidance in care plans around the specific needs of people. Care plans did not provide staff with sufficient information so they could respond positively and provide people with the support they needed in the way they preferred. One staff member told us, "The care plans aren't great. They vary. Also some [staff] are better at using the [electronic care plan system] than others. Some just open the summary and think that is the whole care plan."

● Assessments did not always take into account current legislation and consider relevant nationally recognised evidence-based guidance.

● Care records did not demonstrate that people had been involved in writing them. Some relatives did not feel that the service had actively encouraged them to be involved with care planning.

● There was not an activity co-ordinator in the service. On each shift a member of staff was allocated to undertake activities on the downstairs unit. No member of staff had been allocated the responsibility of ensuring activities were completed in the upstairs unit.

● We observed that throughout the majority of the day, people were sat for long periods of time with limited interaction from staff. One activity record we reviewed showed gaps of three and four days where no activity had been recorded. We could not be assured that activity provision was meaningful for people. For example, on one entry an activity was noted as, "Gone outside to get some fresh air", and, "Enjoyed their meal". This did not demonstrate that people were supported to undertake activity that was interactive and meaningful.

● The provider had not used utilised evidence-based guidance when designing the building for people living with dementia. For example, the majority of communal areas were painted white. For a person living with dementia it can appear that the room all blends into one, and can cause visual misinterpretation, confusion or anxiety. There were no interactive items that people could engage with. One relative told us, "Inside the décor could certainly be improved on. There are certainly no nice pictures or paintings or anything on the walls that would give people with dementia something to see or look at. Everything is so uninspiring in this respect.''

● The service website stated that they were specialists in end of life care. People's care plans held a section on people's end of life needs. However, these were very limited in detail, and in some cases held no information at all.

● We reviewed one person's care plan who was deemed to be on end of life care. However, their care plan just stated to make them comfortable and ensure they have pain relief. There was no reference to their preferences and wishes at the end of their life.

● There was a lack of understanding by management about when to speak to people about their wishes and

were not offering early and on-going opportunities for people living with dementia and people involved in their care to discuss this. They had not considered sudden deaths, and the need to understand what people would want at the end of their life.
● Not all staff had completed recent training in end of life care to equip them with the necessary skills required.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Care plans held information on how people communicated. However, this was often very limited and did not give staff sufficient information or guidance to offer the best possible opportunity for people to give their views and take part in discussions.
● Menu options were written in coloured pen on a whiteboard on both units. However, both were outside of the units where people did not access. One had the wrong date on and was hard to read. There were no photos of the food options on offer or plated up examples so people could make a choice visually.
● The service was not dementia friendly; there was minimal navigational signage, and a lack of interactive activities.

All of the above constitutes a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place. The manager kept a log of complaints.
● Members of the public had complained directly to the CQC about their concerns around the quality of care their relatives received and their concerns for the welfare of people living at the service.
● People we spoke with did feel that if they had any concerns they could raise them with the staff and they would be listened to. Relatives told us that they felt listened to, however, some told us that although they raised issues, they weren't always sure if anything would change. One relative told us, "I give up on the laundry issues. I have time and time again found my relative in someone else's clothing or they have ruined their clothes by washing on too high a temperature."

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.

This is the first inspection for this newly registered service. This key question has been rated as 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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate, placing people at risk of potential harm. The registered manager was not present during the inspection. We were informed they attended the service two days per week.
- Systems for identifying, capturing and managing risks and issues were ineffective. Audits had not fully identified the deficiencies we found at this inspection. This was a failure to manage risks posed to the health, welfare and safety of people.
- There was a lack of understanding among the management team about the Mental Capacity Act 2005, and the importance of ensuring people who lacked capacity were empowered to make decisions about their care.
- Nationally recognised evidence-based guidance was not used when delivering and reviewing care, for example in dementia.
- Relatives told us that communication needed to improve as they weren't always advised of incidents involving their relatives in a timely manner.
- CQC had not always received notifications about safeguarding incidents at the service, and there was a delay in sending notifications about a serious injury. The registered manager is responsible for telling CQC about incidents such as injuries or safeguarding concerns that occur at the service. This meant opportunities to monitor and review the service were not always in place.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider was failing to ensure the service was being run with a focus for people living with dementia with complex and changing needs.
- The service operated a culture that exposed people to the risk of harm. This was partly due to gaps in knowledge in relation to providing care to people living with dementia.
- Care plans did not always reflect people's needs as information was incomplete and not always accurate. This had a negative effect on the delivery of person-centred care.

● Risks that affected people and others were not properly assessed to reduce the risk of recurrence.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received mixed feedback from people's relatives about the quality of the service. Some relatives were happy with the service provided, whilst others expressed concerns.

● Several relatives told us that communication needed to improve. Some relatives felt involved in the care planning for their relative, whilst others did not. One relative said, "My main complaint is about the communication. I have not been asked anything about the quality of the service and have not had any sort of survey to complete or anything like that.'' Another told us, "They don't really ask me for feedback, but I have certainly made them aware of any issues. Whilst they have listened to them, they are not always acted on. They are very willing, but not very effective.''

● Staff we spoke with told us they enjoyed working in the service and were complimentary about the new manager. One staff member told us, "I have never met the registered manager, but the new manager is very 'hands on' and I like them. They listen. I just worry he will be constrained by the provider." Another said, "I do feel valued in my role, and I love my job."

● People told us they liked living at Leaf Park. One person told us that staff were kind when interacting with them but did not always have the time to spend with them if others needed support because they were upset or distressed.

● Relatives benefitted from being able to access a mobile application where they could access parts of the care plan and see what their relative had been doing.

Continuous learning and improving care

● Evidence-based guidance was not used effectively to enhance people's care, and their experiences, given the service was specifically for people living with dementia,

● Some staff told us they had never received end of life care or first aid training. There were drop-in sessions for training which were optional for staff to attend. One staff member was not aware of these, another told us they had never attended any. It was not clear which training was mandatory. We could therefore not be assured that staff received all training relevant to their role.

● Following the inspection, the nominated individual arranged additional training sessions, and set certain training as mandatory going forward.

Working in partnership with others

● The service had worked with the local authority and healthcare professionals such as GP's and mental health teams. However, referrals to specialist professionals such as dieticians had not always been made in a timely manner, placing people at risk of harm. One health professional told us, "Communication needs to improve there its not good. We wouldn't feel comfortable asking the service to do certain [nursing] tasks as we couldn't be sure they would follow our advice."