New Century Care (Leolyn) Limited

Leolyn

Inspection report

63 Pevensey Road
St Leonards On Sea
East Sussex
TN38 0LE
Tel: 01424 422063
Website: leolyn@new-meronden.co.uk

Date of inspection visit: 10 and 13 April 2015
Date of publication: 30/06/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected Leolyn Nursing Home on the 10 and 13 April 2015. Leolyn Nursing Home provides accommodation and nursing care for up to 34 older people who require nursing care. The top floor of the home is a designated unit for up to seven people living with a dementia type illness. On the days of our inspection there were 26 people living in Leolyn Nursing Home.

Leolyn Nursing Home is owned by New Century Care Limited and has six other homes in the South East. Accommodation was provided over three floors, with a further lower ground floor with a passenger lift that provided level access to all parts of the home. People spoke well of the home and visiting relatives confirmed they felt confident leaving their loved ones in the care of Leolyn Nursing Home.

A manager was in post and told us they were in the process of registering with the CQC. However we have not yet received the application. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

People and visitors spoke positively of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

People's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as wound care did not have sufficient guidance in place for staff to deliver safe care. Not everyone had risk assessments undertaken that guided staff to promote peoples comfort, skin integrity and prevention of pressure damage. This had resulted in potential risks to their safety and well -being. Staffing levels were stretched and staff were under pressure to deliver care in a timely fashion.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the MCA Code of Practice. We also found that one person was repeatedly trying to get out of the recliner chair placing them at risk from injury.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Information was not always readily available on people's life history and there was no evidence that people were involved in their care plan. The lack of meaningful activities for people with dementia at this time impacted negatively on people's well-being.

Whilst people and visitors were complimentary about the food at Leolyn Nursing Home, the dining experience was not a social and enjoyable experience for everybody. People were not always supported to eat and drink enough to meet their needs.

Quality assurance systems were in place but had not identified the shortfalls we found in the care delivery. Staff had not all received training in dementia and challenging behaviour to meet people's needs.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated they had built rapports with people and people responded to staff with smiles. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time and from a registered nurse. However we found poor recording of skin creams, dietary supplements and as required medication.

Feedback had been sought from people, relatives and staff. 'Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded, but not consistently audited and investigated with a robust action plan to prevent a re-occurrence.

Staff told us they thought the home was well managed and the communication systems introduced supported them to deliver good care. Their comments included "We work well but need more staff, we can't do everything."

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Leolyn Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve

Summary of findings

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Leolyn Nursing Home was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual risk assessments to maintain their health, safety and well-being were not in place for everyone and therefore placed people at risk.

People were placed at risk from equipment not suitable for their needs and poor moving and handling techniques.

There were not enough staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

Medicines were stored safely and people received their medicines when they needed them. However recording of skin creams, dietary supplements and as required medication was inconsistent.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Inadequate

Leolyn Nursing Home was not effective. Meal times were observed to be a solitary and inefficient service with food being served to people who were in an inappropriate position to eat. We also saw that staff did not always follow good practice guidelines while assisting people to eat. Senior staff had no oversight of what people ate and drank as not all records were accurate or completed correctly.

Not all staff received ongoing professional development through regular supervisions, and essential training that was specific to the needs of people had not been undertaken. Lack of dementia care guidance and training was a particular concern.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not in place.

Is the service caring?

Requires Improvement

Leolyn Nursing Home was not consistently caring. People and visitors were positive about the care received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. People who remained in their bedroom received very little attention.

Summary of findings

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction. However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported

Is the service responsive?

Inadequate

Leolyn Nursing Home was not consistently responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be investigated and resolved.

Is the service well-led?

Inadequate

Leolyn Nursing Home was not well led. There was no registered manager in post. People were put at risk because systems for monitoring quality were not effective.

The delivery of care was not person focused and people were left for long periods of time with no interaction or mental stimulation. People spoke positively of the care, however, commented that staffing levels could impact on the running of the home.

The home had a vision and values statement but we did not see the values acted on during the inspection.

Staff told us that they felt supported by the management and worked as a team.

People had an awareness of who the manager was and felt that the management team of the home were approachable.

Leolyn

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 10 and 13 April 2015. This was an unannounced inspection. The inspection team consisted of an inspector and an expert by experience who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection, we spoke with 15 people who lived at the home, eight relatives, six care staff, two registered nurses the manager and the area manager for New Century Care (Leolyn) Limited.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at nine care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Leolyn Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Leolyn Nursing Home. Visiting relatives confirmed they felt confident in leaving their loved one in the care of Leolyn Nursing Home. One visiting relative told us, “It’s a good home, I keep a close eye on things.” Another relative said, “I trust staff here.” One person told us, “I feel safe here, staff help me.” However we found there were shortfalls which compromised people’s safety and placed people at risk from unsafe care.

Peoples’ risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. The organisation uses care documentation that includes a range of individual risk assessments, which covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at the identified risk and included a plan of action. However we found that not everyone’s health, safety and wellbeing was assessed and protected. For example, one person had not had any initial risk assessments completed since moving in. The person had no documentation in place apart from a pre-admission assessment and a social services placement plan. None of which had been used to formulate an initial care plan to keep them safe and promote their wellbeing. This person was put at risk due to staff not having an understanding of their needs. For example staff had placed the person in a recliner chair to prevent them walking as they felt the person might be at risk from falls when left unsupervised. We saw this person was distressed, and continuously trying to get out of the chair. Staff said they had not seen a care plan and had not read the pre-admission document. The manager had risk assessments to manage this person’s safety and well-being for this person were in place by the end of the inspection.

Risk assessments did not include sufficient guidance for care staff to provide safe care and other care plans were not being followed. For example, one person had a pressure wound. The wound had been assessed but lacked up to date information on the status of wound and the dressings being used. There was no documentation on the wound chart or in daily notes to evidence that the wound had been checked or redressed since 28 March 2015. Staff could not tell us if the wound had been redressed or checked.

Good skin care involves good management of incontinence and regular change of position. There was guidance for people in bed to receive two - four hourly position changes and the use of a pressure mattress. However for people sitting in chairs or wheelchairs there was no change of position or toilet breaks in their care directives for staff to follow. During the inspection, we observed people sitting in the communal lounges for long periods of time without a position change or the offer a change of position. We identified that throughout the inspection, five people had not been assisted to access the toilet or offered a change position in over 7 hours from 10.30am until 5pm. There was no guidance in the care plan to ensure staff managed people’s skin integrity safely with regular checking and movement of position whilst in communal areas. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. These people were therefore at risk from pressure damage.

Accident and incident records were difficult to track at this time as they were not in any order or audited. For example, we found untitled photographs in the front of one person’s care plan. The photographs evidenced extensive marks on the person’s body and staff had not known the cause. Staff had mentioned ‘photographs taken of unknown marks to body’ in the persons care plan. However there was no supporting documentation of actions taken or investigation in to cause. We found that there was an observation documented that marks had ‘gone’ but nothing documented as to staff monitoring the persons skin or prevention of damage. An accident/incident form had not been completed. This meant that no preventative measures were put in place to prevent a re-occurrence and protect the person from harm.

The skills in moving and handling people were varied. We observed two instances where people were being supported to move from a wheelchair to armchair with the support of hoisting equipment. The people were not supported safely by the two staff members. There was little verbal support or reassurance from staff to the person being moved. This was not a safe or pleasant experience for them. We did however also see people moved with skill and expertise and so.

We saw care staff assist people who had slipped in their armchair inappropriately by means of using a 'drag' lift. A 'drag' lift (underarm lift) is any method of lifting people where staff place a hand or arm under the person's armpit. Use of this lift can result to damage to the spine, shoulders,

wrist and knees of the carer and, for the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. We also observed one person moved in bed by staff pulling them gently upright so they could eat their meal. This placed both staff and person at risk from injury. Staff told us that there was "Not enough equipment in the home to move people safely, only one full hoist (lifting equipment) on each floor. Therefore it's a rush to move people and some staff don't follow the correct procedures." There was one full hoist on each floor and we observed that people had to wait for assistance. Following the inspection we received information that there were five full hoists in the building. However when we asked staff about equipment during the inspection, they told us there was only one hoist per floor and not one on the ground floor where the communal areas were. This meant staff were not aware of the availability of equipment to safely move people. This had resulted in staff using inappropriate and unsafe moving techniques. It also impacted negatively on people receiving continence promotion and incontinence care and placed people at risk from skin damage. People were not protected from avoidable harm due to inappropriate moving and handling techniques. All of the above issues demonstrate that people were not protected against the risks of receiving care or treatment that was inappropriate or unsafe.

Personal emergency evacuation plans (PEEPs) were in place but were not easily accessible and were found lacking in guidance for safe evacuation. PEEPs stated one person required one or two people but no further information to guide staff in the safe evacuation of each person. Staffing levels decrease in the evening and night time and this was not reflected in individual PEEPs. This meant people were potentially at risk from harm from unsafe procedures.

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

Staffing comprised of six care staff on the day shift in addition to the registered nurse. The manager was supernumery to the staffing levels. The home had accommodation on three floors and the lower ground floor had a dining and lounge area. Three waking staff provided support at night with one nurse. At the time of our inspection, the majority of people living in Leolyn Nursing Home needed total support with all of their needs. People required two staff to assist them with all personal hygiene needs and assistance with mobilising. We were told the provider used an informal staff ratio of 1 staff member to five people, this did not reflect the documented needs of people.

The delegation and numbers of staff was inappropriate to meet the needs of the people. We saw that staff were busy throughout the day and that care was not delivered in a timely manner. Personal care to get people up for the day was still being undertaken at 12:40 pm and this was not people's individual preference. This meant that people had not an opportunity to enjoy their morning as they were waiting for staff. One person told us, "It can be lunchtime when I get a wash, then its lunch. But they are lovely." Another person said, "I get help to wash, but it varies what time if they are busy."

We looked at care delivery records and found that people were not receiving baths or showers as their preferences stated. For some people there was nine to ten days where they had received a wash but no offer of a shower or bath. Staff told us, "There's not always time and we do wash them properly." Another staff told us "Shifts can be hectic in the mornings and in the evenings, especially if residents aren't well" and, "Sometimes there is not enough time to do everything as I would like to."

The staff struggled to provide care and to supervise people in communal areas. On the top floor there were six people who lived with dementia, who were supported by two care staff. There were three people in the lounge without staff supervision or interaction. The staff tried to ensure people were safe, but were also trying to deliver personal care to other people. As identified above, one person was distressed and was trying to get out of the recliner chair, was struggling and falling back. Staff could not give the necessary reassurance and support, which placed this person at risk from harm.

As identified above personal emergency evacuation plans (PEEP's) were in place but staffing levels especially at night would not be able to respond to the actions detailed, due to the layout of the home and only four members of staff. This placed people at risk from failed emergency evacuations.

Inadequate

Is the service safe?

Accident and incident reports recorded a number of unwitnessed falls of people in communal areas, this indicated that staff were not present and people were therefore not adequately supervised.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had appropriate arrangements in place for the safe management of medicines. There were records of medicines received, disposed of, and administered. However we found that people were at risk of not receiving medicine as they required it, such as paracetamol (PRN Medicines) due to lack of guidance and risk assessments. We looked at six people's care documentation that were prescribed PRN medication. PRN medicine should only be offered when symptoms are exhibited. Such as pain relief medication. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. Six people who received PRN did not have a PRN care plan detailing when the medicine should be administered.

However we saw a nurse administering medication sensitively and appropriately. They asked people if they were ready for their medication. Nobody we spoke with expressed any concerns around their medication. One person said, "I have tablets twice a day and I get it on time."

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider of Leolyn Nursing Home and bank nurses all had registration with the Nursing Midwifery Council (NMC) which was up to date.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." "The carers are very good." However, we found at Leolyn Nursing Home did not consistently provide care that was effective.

Staff were not working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us, a majority of people would be unable to consent to care and treatment. However mental capacity assessments had not been undertaken. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. We asked the staff to talk us through how they completed the mental capacity assessments. They were unable to tell us how they undertook the assessments or the steps needed. We were informed, "We decided on bed rails and we act in people's best interest when giving care." This told us mental capacity assessments were not undertaken, were not decision specific and were not recorded in line with legal requirements.

Training schedules showed us that not all staff had received Deprivation of Liberty Safeguards (DoLS) training or MCA training. Care staff had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, "We have to offer people choices and give them information to enable them to make a decision, of course some can't speak or understand, so we do it but look for distress or resistance." Another member of staff told us, "We monitor body language and facial expressions for signs of consent."

In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. During the inspection, we were informed by the manager that two DoLS application had been made, however other staff were not clear who was under a DoLS. There were people at Leolyn Nursing Home where DoLS applications should have been submitted as there were key pads on the doors of the dementia unit which were not reflected in people's care plans and people had not consented to. We saw people restricted from moving by tables in front of their chairs, unable to get out of recliner chairs and bed rails used without a specific assessment undertaken. These demonstrated staff did not have a full understanding of the MCA and DoLS

There were no individual mental capacity assessments for people living at Leolyn Nursing Home on how their freedom may be restricted or what least restrictive practice could be implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people told us the food was 'good', 'lovely and tasty', we observed that the lunchtime experience on the first day of the inspection process was not structured and was not a pleasurable experience or made to feel like an enjoyable event for people.

The main dining area and lounge was on the ground floor, however only two people took their meals in there on the first day of the inspection. We were told that usually only three people chose to eat in the dining room. Other people either ate in the lounge area or in their bedrooms. People told us that they were not routinely asked if they wanted to go to the dining room. One person said, "I suppose I could ask but I don't want to be a bother."

The top floor which was specifically for people who lived with dementia ate in their chairs in the small lounge or in their bedroom. We observed people being assisted with their midday meal and staff stood while they assisted them. There was no eye contact and the person did not get the staff member's individual attention. We also observed a staff member assisting more than one person at the same time. The television remained on and people's attention was not focused on eating. One person kept their head down and was dozing off and on until staff returned periodically to assist them to eat. These examples of poor practice meant that people did not get assistance in a way that ensured they had an enjoyable meal experience.

On the ground floor five people remained seated in the lounge area and either had small tables to eat their meal from, or received one to one support to eat from their armchair. One person sat at an angle in their chair which meant they couldn't fully see their plate on the table. This person experienced difficulty in eating their food independently and ate very little. A staff member later assisted them but the meal was by then cool. We asked about special equipment such as plate guards and angled

cutlery to assist people to eat and promote their independence. We were told it was kept in the kitchen and not routinely used. One person's care directives from the speech and language therapist (SALT) stated to use an open cup/beaker for all beverages and to be closely supervised. It specifically stated that a beaker and spout was not to be used. We saw staff give this person their beverages from a beaker with a spout and left unsupervised. When we spoke with staff they acknowledged that they had not followed the directives. One staff said, "Well, we can't supervise as we have other residents to assist." This placed this person at risk from choking and fluid aspiration.

People that remained in their room received their food and staff checked intermittently that they were eating, but this was not consistent on all floors. We observed people sitting with food uncovered, waiting for staff to assist or prompt them to eat. This meant that the food was luke warm. Staff assisted people in bed to eat by standing and reaching over bed rails. There was little interaction and it was not an enjoyable experience for people.

The meal was attractively presented by the cook, who was knowledgeable of people's specific dietetic requirements such as soft, fork masheable or pureed. Pureed food was attractively presented and recognisable as meat, vegetables and potato but prior to feeding people staff mixed the food together. It was then unrecognisable and people were unable to identify the food they were eating. Much of the food was returned uneaten and poor appetite trends may not be picked up, as meal returns were not recorded.

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from dehydration and malnutrition. There were records for people at risk from dehydration and malnutrition that were incomplete and not totalled, and therefore would not be an effective way of monitoring their health. Most fluid charts stated that the maximum fluids to be taken in 24 hours was 2000 mls but records stated their input was variable, for example, records showed the persons input of fluids on five consecutive days ranged between 450 mls to 600 mls. We also noted that for eight of the 12 records looked at no-one received fluids after 5pm and received no drinks until 8am the following day. Food records for some people also demonstrated they ate very little and weight records showed weight loss for certain people, two of which had been referred to a dietician. There were others who were considered stable but with a low body weight, not all had plans of action to prevent further weight loss. The staff had not ensured that people received suitable and nutritious food and hydration which is adequate to sustain life and good health.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Whilst training was available it was not effective in all cases. We observed poor practice in moving and handling people, assisting people with their food and in ensuring peoples safety whilst distressed and agitated. Staff received an induction programme which lasted a month and ongoing training support. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. This was confirmed by a member of staff who said, "The induction was pretty good, staff were supportive." However poor practices observed meant new staff would not be learning the correct way to deliver effective care.

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said "Supervision has been a bit irregular but we have had changes." Other staff said that they could not confirm regular supervision.

We looked at training records and saw that staff accessed training via the internet from an e-learning provider. Training records indicated that fundamental training for all staff was not up to date. For example infection control, safeguarding, health and safety. Service specific training, such as dementia care and managing behaviour that challenges had not been undertaken. We saw care delivery for people who lived with dementia was not always appropriate. Staff were unclear of how to support people who displayed agitation and distress. This impacted negatively on people's well-being. Staff feedback in respect of E learning was mixed. Some staff admitted to being unclear of what training they had completed and relied on

Inadequate

Is the service effective?

the provider for reminders. One staff member said they had not received training in caring for people who lived with dementia despite working on the dementia floor. This meant people who lived with dementia were not benefitting from trained and effective staff.

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did receive effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. One visiting relative told us, "My relative picks up infections so easily, staff." Staff recognised that people's health needs could change rapidly especially for people living with a deteriorating illness, such as Parkinson's disease, and advanced dementia. One staff member told us, "We monitor for signs, changes in their mobility and facial expressions which may indicate their health is deteriorating.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they or their loved one received. Visitors told us, "They speak to residents, have a respectful approach, keep the place clean, and treat them well," and "My relative is cared for." However this was not fully supported by some of our observations

Some staff did interact with people in a caring manner, but we also observed instances when staff did not engage positively with people. Staff assisted people in a calm and kind manner, but did not ensure comfort by verbal reassurance or display empathy with people's mental health needs. One person was calling out and shouting, and staff accepted this behaviour rather than exploring the reason or finding a way to reassure the person. We saw some people who were unable to interact independently had little interaction during our inspection.

Staff told us they promoted people's independence and respected their privacy and dignity. Staff knocked on bedroom doors and waited for a response before they entered. Staff also greeted people respectfully and used people's preferred names when supporting them. One staff member commented on how they encouraged people to be as independent as possible. However this was not supported by our observations. For example one person we spoke with said, "I would like to be assisted to do more on my own, staff sometimes assume I need it done for me, I suppose I am slow and staff are quicker." We also noted two instances where people were brought in to the lounge with minimal interaction, nor did they ask where they would like to sit. Hot drinks were served and people were not offered a choice, but given their usual. Staff said, "It is what they want."

Our SOFI identified that on the dementia floor verbal interaction was minimal and staff did not engage with the people they supported as they were focused on completing personal care. We saw an example where a person was calling out for long periods of time. When asked staff said, "It's normal and they are quieter when in lounge, that is why we move them in to the lounge." When asked about other reasons for the calling out, staff said they weren't sure, but felt it was normal. The care plan did not reflect any research or management strategies for the person's behaviour. Three people who had complex dementia health needs spent long periods of time alone in the top floor lounge area in recliner chairs. Apart from the television and films there was little to provide or promote interaction.

Observations throughout the day identified that staff did not always offer people a choice or listen to what they wanted. In the main lounge, people were placed in chairs for long periods without a change of position or being asked if they wanted to sit elsewhere. The television was on but people were not asked if that was what they wanted to watch. We heard staff tell people, "Oh you will like this and changed the channel, without asking the people or telling them what was on." One person told us, "I don't think they have time to listen, but they are kind and that is what matters." This had not fully enabled people to make everyday choices important to them and to meet their identified needs. One member of staff told us, "We try to ensure that people are given choice and make decisions for as long as they can but many can't, so we do it for them." This did not promote people's independence or autonomy.

People told us they were well cared for. One person told us, "They are very kind." Another person told us, "I'm very happy here." However documentation on when people received oral hygiene, showed that people could go five days without having their teeth cleaned. Staff informed us, "Care staff should be recording in people's daily notes why oral hygiene was not given." The sample of daily notes we looked at did not always record when an individual received care or if personal care was offered. We could therefore not tell if people received regular support.. This meant we could not be assured that people's personal hygiene needs were being met.

We noted that one person was wearing torn clothes and that staff had not noted this until we raised it with them. Staff were unsure of how the trousers had been torn.

Whilst talking with one person who was distressed, we looked at the admission notes and found that they needed to wear glasses and that they were hard of hearing. However staff were unaware of this as the information had not been passed on to them or written in the room care profile. A room care profile contains important information for care staff to support people, such as communication, mobility, personal care and dietary needs. The person did not have their glasses.. The glasses were found in their room and the person became calmer when their glasses were available to them.

Requires Improvement

Is the service caring?

One person had moved rooms from the nursing floor to the dementia floor. When we visited the room, we found the person's clothing unpacked and still in black plastic bags. There was equipment in their room that belonged to the previous occupant and staff were unaware that this was not theirs despite it being the wrong size and height. The person's personal belongings were not displayed for them to access. This meant the person could not be comforted by their familiar belongings at a time when they were in unfamiliar surroundings with people they did not recognise.

People were not treated with dignity and respect in ensuring their personal care needs were met consistently. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see that staff interacted with people in a kind and compassionate way when they had time. When talking to people, staff maintained eye contact and sat down next to the person. Staff had clearly developed rapports with people and people responded to staff with smiles. Staff we spoke with spoke positively of the home and confirmed they enjoyed their work. One person who lived in the home told us, "Very caring and kind, I am so happy that I came to live here, they ensure that I am supported." Another person said, "Excellent couldn't live in a better place."

People commented they enjoyed the company of staff. One staff member was observed sitting with visitors and the person they were visiting and joining in the music session. The visitor said, "I don't have any worries at all."

Inadequate

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that the service listened to them. However, we found Leolyn Nursing Home did not consistently provide care that was responsive to people's individuality and changing needs.

Communication and social well-being was an area that we identified as a concern, as there were people isolated in the lounge areas and bedrooms with little interaction. People that were mobile and able to communicate with words interacted with each other, visitors and staff. However, people who could not communicate with words were left for long periods of time without staff intervention. Staff were seen in the communal areas, but due to time restraints did not actively engage with people. This was very noticeable during the morning. On the top floor (dementia unit) there were six people who lived with dementia with two members of staff. The two members of staff said that due to the complex needs they worked together to wash people and this left them unable to supervise the people already up and in the lounge. The television provided the only stimulation in the communal lounge. Staff could not spend time with the people in their bedrooms and we observed that people were only interacted with at meal time or during personal care. The lounge was not large enough for all the people to be accommodated and did not provide any activities to engage people or respond to their social needs. The environment and atmosphere therefore was unstimulating and not dementia themed. We were told that one to one sessions with people that were unable to join people in the main communal areas took place. However staff weren't sure of how often and t documentation did not evidence that this happened on a regular basis. Therefore we could not be assured that people's individual social needs were being met and that people received positive and appropriate interaction.

Activities were undertaken by an identified staff member whose role was to co-ordinate activities. The activity co-ordinator invited entertainers to the home and arranged activities that people could attend. People told us that not much that interested them was on offer, but they enjoyed entertainers and were looking forward to the better weather. One person told us that boredom was a problem and felt that more could be introduced so they could participate and meet up with other people. The majority of care plans we viewed identified social needs and communication as part of their assessed identified needs, but lacked guidance and information as how to specifically meet individual people's needs. We looked at whether there were meaningful activities for people. There were people who would benefit from activities that added to their lives, such reminiscence activities and life books for those that live with Dementia and arts and crafts and visits out to enjoy art galleries. These suggestions came from people, relatives and staff. We were informed that this was being looked in to.

There were people who lived with dementia that spent large periods of time on their own. Staff called out to people as they walked past their rooms whilst carried out other duties, but were not seen to enter the rooms to reassure them or respond to the answers. We visited people in their bedrooms and some people were lying in bed with nothing to visually engage with or listen to. There was little guidance in people's care plans to guide staff in ensuring that their social needs were being met. One person was sitting up and was alert but there was nothing in reach for them to engage with or for them to listen to or watch. Staff said this person enjoyed company but this was not readily available to them. The care plan for this person contained no information that gave staff guidance as to this person's preferences and interests or how to support their social needs. Staff told us that this person needed and enjoyed company and became withdrawn and agitated when bored.

We observed people spent a considerable amount of time in the lounge without staff being present. We sat in the lounge for 45 minutes and did not see a member of staff. People there had no access to call bells to summon assistance. One person's sitting position meant they were unable to see the television or interact with other people. This person had no other form of stimulation such as a book. This person spent long periods of time dozing but enjoyed interaction when approached by staff.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs,

Inadequate

Is the service responsive?

chiropodists, opticians and dentists and had attended regular appointments about their health needs. However the care plans lacked details of how to manage and provide person specific care for their individual needs.

People's continence needs were not always managed effectively. Care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking or prompting to use the bathroom throughout the day. We asked staff about continence management and they could tell us who was incontinent and who required prompting and assistance. However we saw four people sat for up to six hours in the lounge without being offered the bathroom or being taken to freshen up. There was no mention of promotion of continence to prevent incontinence. People's continence needs can be managed by regular prompting and responding to body language and timings for drinks and meals.

The sample of daily notes we looked at did not always record when an individual received care or if personal care was offered. We could therefore not tell if people received regular support to bath or shower. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. This meant we could not be assured that people's personal hygiene needs were being met.

The evidence above demonstrates that delivery of care in Leolyn Nursing Home at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

A complaints procedure was in place and displayed in the reception area of the home and provided to people in an accessible format. Most people told us they felt confident in raising any concerns or making a complaint. One person told us, "I know who to talk to and am confident that I will be listened to." We looked at the complaint log and found that all complaints were recorded and responded to within the timeframe stated in the organisational policy. We saw records of investigation and action plans set out. We also saw that the home received thank you cards and compliments which were shared with staff.

Inadequate

Is the service well-led?

Our findings

People, friends and family and staff all described the management of the home to be approachable, open and supportive. People told us; "Approachable and kind," and "Helpful." A relative said; "I think the change of managers has been unsettling, but things are good now." A staff member commented; "The management are supportive, they come out onto the floor, they're not just stuck in their office."

There was no registered manager in post. The manager was previously the deputy manager and was placed as acting manager following the resignation of the previous registered manager in January 2015. The role of manager was confirmed and accepted in March 2015. We were informed that the manager was in in the process of submitting their application to be registered as manager.

Whilst there were quality assurance systems in place, they had not identified that people's safety was potentially at risk from inadequate staffing levels and that impacted on care delivery.. Some care plans were lacking in specific information that had the potential to cause harm to the individual. We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints. We also found that people's nutritional needs were not being managed effectively and monitored to ensure that people had enough to eat and drink. The care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example management of wound care and continence. The environment and equipment for people who lived with dementia was not suitable to support people safely.

People had not been protected against unsafe treatment by the quality assurance systems in place. This was a breach of Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. Staff were able to tell us, "The vision of the home is to put the person at the centre. This is their home. When I first started working here, the culture was not good, the vision was not clear but I've been working on that and we are improving, we want to be a centre of excellence." Staff we spoke with had an understanding of the vision of the home but from observing staff interactions with people; it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. Staff however spoke positively of the culture and how they all worked together as a team, this was said by all staff we spoke with. They said they supported each other and helped out on other floors if they were busy. The staff talked about how they wanted to improve and be able to put people at the centre of what they do.

People, staff and visitors said that communication and leadership had improved within the home and the atmosphere was pleasant. Staff and visitors had an awareness of the management team and felt that the morale of staff had improved. As we saw on the day of the inspection the staff worked hard but shortcuts in care delivery were noted due to time constraints and staff shortages. This meant people did not always receive the care they wanted and required. For example social interaction, mental stimulation and promotion of independence and mobility.

The manager told us one of their core values was to have an open and transparent service. The provider sought feedback from people and those who mattered to them in order to enhance their service. Friends and relatives meetings were regularly held and surveys conducted that encouraged people to be involved and raise ideas that could be implemented into practice. People had meetings to discuss specific topics for example, meals and activities within the home. People and relatives told us they felt their views were respected and had noted positive changes based on their suggestions. Such as food choices and independence promotion.

Staff meetings were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice. If suggestions made could not be implemented, staff confirmed constructive feedback was provided. For example, one member of staff commented; "I raised suggestions about training, the manager took my comments on board, spoke with staff and we are going forward."

A new senior new management team came in to post in January 2015 and were undertaking organisational audits which had identified some of the shortfalls found but work to improve had not yet progressed. It had been identified that a deputy manager with clinical expertise was required to support the manager and a registered nurse has been

Inadequate

Is the service well-led?

recruited to the post. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider had not ensured that the nutritional and hydration needs of service users were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured that service users were treated with dignity and had their privacy protected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:
Warning notice