AAA Medics Ltd

Leylands Rest Home

Inspection report

16-18 Leylands Lane
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West Yorkshire
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10 October 2017
13 October 2017
16 October 2017

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

Summary of findings

Overall summary

This inspection took place on 10, 13 and 16 October 2017. The first day was unannounced. At the previous two inspections in January 2016 and February 2017 we rated the service as 'Inadequate' and in 'Special Measures'.

At our inspection in February 2017 we found seven breaches in regulations. These related to staffing, person-centred care, dignity and respect, consent, the premises, safe care and treatment and good governance. The Care Quality Commission took enforcement action in relation to these breaches.

Leylands Rest Home is registered to provide accommodation and personal care for up to 17 older people, including people living with dementia. There are nine single and four shared bedrooms, each with en-suite facilities. There are two lounges, a dining room and a bathroom on the ground floor. At the time of this inspection there were six people living at the home.

The registered manager left the service following our inspection in February 2017. A new manager was appointed but, at the time of the inspection, had not made application to the Care Quality Commission to become registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Standards of infection control were poor and not all of the necessary environmental safety checks had been completed.

Staff were not working to people's care plans to maintain their safety.

Staffing levels were increased during our inspection as we identified there were not enough staff available to meet people's needs.

Staff had been recruited safely but had not had the training they needed to support them in their roles.

Risk assessments were in place but did not include detail of actions staff should take to mitigate risks to people.

Accidents and incidents were recorded, however, they were not analysed and there was no evidence of learning or actions taken to reduce the risk of recurrence

The service was not always working within the principles of the Mental Capacity Act (MCA) and Deprivation

of Liberty Safeguards (DoLS).

We found people had access to healthcare as needed.

Standards in relation to nutrition and food provision had improved and people told us they enjoyed the food at the home.

Staff appeared caring in their approach but did not meet people's needs in relation to privacy and dignity.

People were not provided with appropriate and person centred stimulation.

There was not a registered manager in place and the provider had failed to provide effective and strong leadership. Quality assurance systems had been put in place however these were not appropriate or robust which is evident from the continued breaches we found at this inspection.

We found shortfalls in the care and service provided to people. We identified seven continued breaches in regulations. These related to staffing, person-centred care, dignity and respect, consent, the premises, safe care and treatment and good governance.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'Special measures'.

The Care Quality Commission are taking enforcement action in response to the provider's failure to improve standards of quality and safety within the home. Full information about The Care Quality Commission's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The provider made a decision to close the home shortly after the conclusion of this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Effective systems were not in place to keep the premises safe, clean and control the spread of infection.

Staff did not work in line with people's care plans to maintain their safety.

Medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff training was insufficient to ensure they had the skills and knowledge to meet people's needs.

The service was not meeting the legal requirements relating to The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received nutrition appropriate to their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity needs were not met.

People were complimentary about staff and we observed some caring interactions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with appropriate and person centred stimulation.

Care plans were in place based on assessment of people's needs.

Is the service well-led?

Inadequate

The service was not well-led.

There was not a registered manager in post.

There was a lack of effective auditing of the quality and safety of the service.

Leylands Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 10, 13 and 16 October 2017. The visits on 10 and 13 October were unannounced and we informed the provider we would return on 16 October.

On the first visit the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has experience of using or supporting someone who used a residential care service. On the second visit the inspection team consisted of an adult social care inspector and an adult social care inspection manager. Two adult social care inspectors concluded the inspection on the third visit to the home.

We reviewed information we held about the service, such as notifications, information from service commissioners and safeguarding teams. We also contacted Healthwatch, which is an independent body which represents the views of people who use health and social care services in England.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people who used the service and a visiting relative. We also spoke with four members of care staff, one member of cleaning staff, the home manager and the provider.

We looked at a variety of documentation including; care documentation for six people, three staff files, meeting minutes, policies and procedures, medicine administration records and quality monitoring records.

Inadequate

Is the service safe?

Our findings

We found staff were not always working in line with people's care plans in order to meet their safety needs. Additionally we found staff's recordings of checks to ensure people's safety were inaccurate.

At our previous inspections in January 2016 and February 2017 we found breaches of regulation in relation to environmental safety and infection control. We took enforcement action in relation to these continued breaches.

On this inspection we found continued breaches. For example we found faecal smearing on bedroom walls, beds and mattresses. We also found the provider had failed to take the actions identified as necessary in a fire risk assessment in April 2017 to promote people's safety in the event of a fire.
We saw accidents and incidents were recorded, however, they were not analysed and there was no evidence of learning or actions taken to reduce the risk of recurrence.

Within people's care records we saw risks to their safety and welfare were identified. These included falls, pressure sores, nutrition and behaviour which challenged. However we found there was a lack of detail about the action staff should take in response to behaviours which challenged. For example, in one person's record we saw "Need help from 2 staff to help wash and can become verbally and physically aggressive." We found no information or guidance for staff to follow to reduce the risk. One care worker spoken with said, "We have never been informed how to respond when (person) become verbally or physically aggressive she just lashes out."

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

At our last inspection we found there were not enough staff to meet people's needs. We took enforcement action in relation to this breach.

On the first day of our inspection we asked staff if they thought there was enough staff to keep people safe. One member of staff told us "No, when we have two people needing help other people are left unattended."

We saw from staffing rotas that two members of staff were on duty over the 24 hour period. The manager worked approximate office hours Monday to Friday.

The manager told us three of the six people living at the home required the support of two staff to meet their personal care needs. This meant that when both staff were required to support a person, there were no other staff available to the other people. We raised this with the manager during feedback.
This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we returned three days later we found the staffing levels had been increased to three staff between

the hours of 8am and 8pm.

We spoke with staff about their understanding of protecting vulnerable adults. Staff had an understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. All the staff we spoke with said they would report any concerns to the manager. Staff said they were confident the manager would respond appropriately.

We found systems for managing medicines had improved and found medicines were stored and administered safely.

We looked at recruitment records for three staff and found safe recruitment procedures had been followed.

Inadequate

Is the service effective?

Our findings

At our inspections in January 2016 and February 2017 we found breaches of regulation in relation to staff training. We took enforcement action in relation to these continued breaches.

On this inspection we found staff had not received the training they needed. For example, four staff had not received moving and handling training.

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

At our inspection in February 2017 we found the service was working not within the principles of the MCA. We took enforcement action in relation to this breach.

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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

The manager told us three people living in the home had DoLS authorisations in place. We saw one had been granted with no conditions. When we asked to look at the DoLS authorisation for a second person, the manager was not able to locate it. We asked on our third visit if the authorisation had been found and the manager said not. The other DoLS was not in place as it had expired June 2017 but this had not been recognised until October 2017. This meant that staff were not aware that the person was not subject to a DoLS authorisation during the period June to October 2017.

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

Staff we spoke with said they had received training about the MCA. Staff had good knowledge around when they should support people with decision making and when people had the right to make decisions even though these might be unwise.

We saw in people records they were supported through regular contact with health professionals. Records showed arrangements were in place that made sure people's health needs were met. Visits by health and

social care professionals were recorded in people's care records, together with notes relating to advice or instructions given.

We saw improvements in the standard of food provided at the home and people received snacks and drinks in line with their nutritional needs.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2017 we found staff did not always meet people's dignity needs. We said this was a breach of regulation. We took enforcement action in relation to this continued breach.

On this inspection we found continued failure to meet people's privacy and dignity needs. For example, we found different people's clothing, including underwear in people's wardrobes and drawers. We also saw faecal smearing identified to the manager on the morning of the first day of the inspection had not been cleaned before the person had been supported to have bed rest during the afternoon.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated a caring approach and knew people well. People we spoke with were complimentary of the care they received from staff.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2017 we found people were not provided with appropriate and person centred stimulation. We took enforcement action in relation to this continued breach.

On this inspection we saw people's activity schedules were not based on their individual preferences and did not promote independence. Although staff spoken with told us activities took place, we did not find evidence of this in people's care files.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care plans and supporting documentation in place for three people who lived in the home. Care plans contained an assessment of people's care and support needs carried out before they began to use the service. This meant the provider had checked to make sure they could meet people's needs. From this assessment risk was assessed, and a series of care plans written. However we found people's life history was not recorded, consent summary were not signed or dated. The care records contained some information about people's likes and preferences for care and support. This included foods they liked to eat and sleeping arrangements.
A complaints procedure was displayed on the wall in the entrance hall. The manager told us no complaints had been received since the last inspection.

Inadequate

Is the service well-led?

Our findings

At our inspections in January 2016 and February 2017 we found breaches of regulation in relation to governance of the service. We took enforcement action in relation to these continued breaches.

On this inspection the manager told us there was a quality assurance monitoring system in place designed to ensure the quality of the service and drive improvement. We saw there was an audit plan in place and a range of audits were undertaken by the manager and other staff.

However, it was apparent that while the audits were being carried out they were not always appropriate to the service, had not always identified shortfalls and there had been a failure to take timely action to address the concerns identified.

An example of this was the infection control audit in which staff had ticked to say items such as macerators and bed pan washer were clean and in good working order when the home did not have such items. The audit had also been ticked to say that all aspects of the treatment room had been checked. The manager confirmed the service did not have a treatment room.

Additionally a fire risk assessment carried out in April 2017 had identified risks to people and required actions to be taken within 30 days of the assessment. Several of these required actions had not been completed.

We found little evidence of the involvement of the provider in the audit of safety and quality in the home. The provider told us they had made frequent visits to the home and had made records of these but they were in a book which had gone missing from the home. We were later shown, by the manager, four pages torn from a book which we were informed were records of the provider's visits. We were told these were from the book the provider thought was missing but had been located at their home.

The records in the book gave little detail of auditing. When we asked the manager if the provider had shared their findings of the visits or given an action plan, the manager said not.

There was no evidence of the provider or manager having oversight of audits completed by staff.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.