Quality Homes (Midlands) Limited

Leighswood

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 31 January 2017. At our last inspection in February 2016 we rated the provider as 'requires improvement'. The provider needed to make improvements to the care they provided under the key questions of whether they were 'safe', 'effective' and 'well-led'. At this inspection we found the required improvements had not been made. The service provided to people had deteriorated and the provider was now not meeting all the requirements of the law.

Leighswood provides accommodation for people who require personal care for up to 23 people. At the time of our inspection there were 22 people living there.

There was a registered manager in post at the time of our inspection. 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.

People were not protected from the risk of harm because staff did not use safe techniques to transfer them around the home. People did not get their medicines as prescribed. Medicines were not always available to people. People were not always protected from harm because the registered manager had failed to take appropriate action when people sustained injuries. People's freedom of movement was restricted because people were directed to one room so staff could monitor them. There was insufficient staff to ensure people got safe care, particularly at night time..

Staff had received some training but it was ineffective as staff were not providing people with safe or effective care. Principles of the Mental Capacity act had not been followed because the registered manager and staff did not have the knowledge or understanding of how to apply the principles to people who lacked capacity to make decisions about their care. Staff did not ask for consent before providing care. Although people told us and we saw they enjoyed the food we could not be sure people had support to maintain their nutritional needs. People did not always have access to health professionals when their needs changed.

Staff did not support people in a dignified way and people's right to privacy was not always respected by staff. People did not have meaningful relationships with staff. Staff did not have the time to spend with people. We saw some staff spoke to people in a disrespectful way.

People did not receive care which was responsive to their individual needs. Staff knew about people's preferred choices but did not always have them time to deliver care in a way which people preferred. People spent long periods of time with nothing to occupy them as they did not have the opportunity to engage with any activities or hobbies or interests. Relatives told us they knew they could complain but when people did make formal complaints we saw action had been taken.

People were not supported by a management team who ensured the care they were receiving was safe. The

provider had failed to monitor the quality of the care people received and to take action when needed. Staff had mixed views about whether they were supported in their role.

During this inspection we identified six breaches of the Health and Social Care Act 2008 relating to safe care and treatment, safeguarding people from harm, staffing, consent, respecting people's privacy and dignity person centred care, and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their 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 we will inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Unsafe moving and handling techniques were used. Systems were not in place to ensure people got their medicines as prescribed or when needed. Risks to people's health and safety were not safely managed. There were insufficient staff to keep people safe. Safe recruitment systems were operated by the provider.

Is the service effective?

Inadequate

The service was not effective.

Staff had received training but had not applied their learning in their practice. The registered manager had failed to apply the principles of the Mental Capacity Act. We could not be sure people were getting sufficient food and fluids to maintain their health. People did not always have access to healthcare professionals when their needs changed.

Is the service caring?

Inadequate

The service was not caring.

People's rights were not protected as staff did not respect their privacy and dignity. Some staff did not support people in a caring way. Positive relations were not always developed between staff and people who lived at Leighswood. People did not always get choices with regards to how their care was delivered.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have care which was responsive to their individual needs. People did not have access to activities of their choice. There was a complaints process in place should people and their relatives wish to complain.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems were ineffective. The registered manager had not taken action to monitor and improve the quality and safety of the service. Not all staff felt supported in their role. There was a negative culture between staff in the home.	

Leighswood

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 31January 2017 and was unannounced. The inspection team consisted of one inspector, one expert by experience and one specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of medicine management and working with older people and people living with dementia.

Before the inspection, the provider completed 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.

As part of the inspection we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We asked for feedback from the Commissioners of people's care to find out their views on the quality of the service. We contacted the local fire service to find their views on the safety of the building. We also contact the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection we spoke with three people who used the service and three relatives. We spoke with the registered manager and four members of staff and a visiting health professional. We carried out observations throughout the day to help us understand the experiences of the people who lived there. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for five people and medicine records for 12 people. We looked at other records relating to the management of the home. These included staff files, accident reports, complaint logs and audits carried out by the registered manager.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2016 we rated the provider as 'requires improvement' under the key question "Is the service safe?". This was because risk assessments did not contain sufficient guidance for staff to follow and when people had topical creams staff had not recorded their administration on people's records. At this inspection we found the required improvements had not been made. The provider was now not meeting the requirements of the law because they had failed to ensure people received safe care and treatment and ensuring there were sufficient staff to meet people's needs.

People's risks were not always managed safely. Staff told us how they managed some people's risks; however we saw they did not consistently provide care to people in the way they explained to us. During this inspection we saw multiple examples of members of staff moving people in a way that caused an increased risk of injury. For example, we saw one person being supported by one carer who was unsteady on their feet. A second carer came to support them and we saw staff used an unsafe technique by supporting them under their arms which at times almost resulted in their feet being lifted of the floor. We looked at this person's care records to see how they should be supported. Records we looked at did not contain sufficient guidance for staff to follow when managing risks to people's health and safety. We saw when one person had repeated falls we saw there was no guidance in place to manage the risk of falls or what staff needed to do to prevent further occurrences. We spoke to the registered manager about how staff should prevent further falls for this person. They told us they had not considered using other equipment such as crash mats to prevent further injuries. The registered manager had not ensured staff had the skills to move people safely .We saw people were at risk of harm because the registered manager did not have systems in place to assess people's risks. For example we saw one person was at risk of repeated water infections and there was no assessment in place to ensure staff knew what how to manage this person's health condition. Although the registered manager told us they should be 'pushing fluids' staff could not demonstrate this as no records were kept of their fluid intake. The registered manager had failed to ensure there was an effective system in place to ensure people's risks were documented and monitored to prevent further deterioration in their health and safety.

The registered manager told us no one who lived at Leighswood required a hoist to move them safely. However, accident records indicated when people were found on the floor at night there was no explanation as to how staff transferred them safely from the floor to a sitting position. A member of staff told us they used 'techniques' but could offer no further explanation. The registered manager told us their procedure was to call 111 or 999 and not to move them. The registered manager could offer us no explanation to assure us people had been moved safely when the above procedure had not been followed. We saw people sustained injuries such as skin tears as a result of falls and appropriate action had not always been taken to protect people from further harm. For example, we saw one person had a plaster on their hand. We asked staff what had caused their injury. They told us it was skin tear and they didn't know how the person had got it or when. We looked at this person's care records which indicated out of seven accidents, three of these had resulted in skin tears all of which were timed as happening at night.

People did not get their medicines on time or as prescribed. We asked people if they got their medicines

when they needed them. Most people were unable to tell us. One person said, "Sometimes I get my medicines on time, sometimes I have to wait. Night times I have to wait". We looked at the system the provider had in place to ensure people got their medicine as prescribed. We found the systems in place were not robust and found people did not always receive their medicines as prescribed. For example, we saw that one person had been prescribed medicines for pain relief. Records indicated the person had not been given their medicine for pain for the two days prior to our inspection because they were not in stock. Records demonstrated they had previously been given their tablet regularly which indicated they needed it. We also noted this person had been prescribed pain relieving gel up to be applied three times a day. Records we saw demonstrated the person had also not been given this as prescribed. The registered manager told us they would contact the doctor straight away to ensure the person had their prescribed medicine. We spoke to this person who told us they did not feel well which we passed on to staff. The registered manager had failed to ensure people got their medicines as prescribed.

We saw on occasion's people's medicine administration records (MARS) were not completed accurately. Staff were unable to tell us if people had received their medicines. For example, we saw one person had been prescribed a medicine to be given weekly to minimise the risk of fractures due to bone thinning and staff were not able to confirm if this person had received their medicine or not. We advised the member of staff that this put them at risk should they fall and medical advice should be sought. The registered manager had failed to ensure staff had the knowledge and skills to administer and record people's medicines correctly.

At our last inspection we noted that when people had topical creams prescribed staff were not recording their application on their medicine records so we could not be assured people were receiving these creams as prescribed. At this inspection we saw the registered manager had introduced a new record for staff to complete when giving people their creams. However, records we saw indicated that staff were not applying the creams in line with how they had been prescribed. For example, we saw one person had a cream prescribed to use twice daily for washing. The four days prior to our inspection records indicated the cream had only been used once a day. We saw creams had been prescribed for people for them to use "as required". There were no records in place to offer staff guidance as to when people exhibit pain or when to apply the cream. We spoke to the registered manager about these errors but they could not offer an explanation as to why people were not getting their creams as prescribed.

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

People's relatives told us there were insufficient numbers of staff available to keep them safe. One relative said, "I visited last week and there was only two staff on and that's not enough. I spoke to [the registered manager] about it and they listened to my worries but I am not sure [name of person] is safe all the time". They told us their relative had had a lot of falls lately and thought that this was a result of insufficient staff. Staff we spoke with also told us there were insufficient numbers of staff to keep people safe. One staff member said, "Some times are worse than others. We have to tell people to wait as a few people require two people to support them". Another member of staff said, "There's not enough staff when there are two on duty at night. When people require two staff to support them sometimes we can't prevent other people from falling". We saw there were times during the day when there were insufficient staff to support people with their care. For example, we saw one person left with food in front of them and staff not having time to support them. We saw by the time staff approached them their food was cold and they did not want it. The registered manager had failed to ensure there were sufficient staff to meet people's needs. During the

inspection we saw staff prevented people from freely moving around their home. We heard one member of staff say to a person, "[Name of person] sit down now and stop walking up and down". People told us they did not like being restricted in this way, with one person saying, "All they do is tell you to sit down". We asked staff why they were restricting people's movement and they told us there were not enough staff to support people to move to keep them safe from the risk of harm.

We spoke with the registered manager about staffing levels and they confirmed there were insufficient numbers of staff available to support people. They told us four night shifts a week were currently understaffed. We saw in the month prior to our inspection that 11 out of 14 accidents had happened at night. The registered manager told us they had not developed a way of calculating how many staff were required, however they did feel further staff were needed to keep people safe. They told us they had requested further funding from the provider to increase staffing levels but this had not yet been granted. We found there were insufficient numbers of staff to meet people's needs and ensure they were safe.

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

Although staff had an understanding of how to recognise signs of abuse and what procedures were in place should they suspect any abuse had occurred, we saw people sustained injuries such as skin tears as a result of falls. We saw on one person's accident record this may have been a result of unsafe techniques being used to move them. We asked the registered manager if they had protected this person by making a referral of the suspected abuse to the local safeguarding team. They told us they had not because they had not seen the accident report. We asked them to make a referral immediately. Following our inspection we saw this had not been completed and we referred the matter to the local safeguarding team ourselves.

We looked at the systems the provider had in place to ensure staff were recruited safely. Staff told us they had been asked to bring in documents before they had been allowed to start work. These included references and other documents to prove their identity. Records we looked at confirmed the provider had a safe recruitment system in place which included Disclosure and Barring (DBS) checks being completed prior to them commencing work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use services. This meant people were supported by staff who were suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

At our last inspection in February 2016 we rated the provider as 'requires improvement' under the key question "Is the service effective?". This was because the registered manager had not fully implemented the requirements of the Mental Capacity Act in the service. At this inspection we found the required improvements had not been made and legal requirements were still not met.

We found staff had a limited understanding of how they gained consent from people. One member of staff told us, "If they refuse we walk away". However, they went on to explain they had heard other staff tell people they had to put their cream on, "whether they liked it or not". We saw staff provided care to people without asking for their consent. For example, we saw one person sat contented in the dining room. Staff interrupted the person without asking and said, "Come on [name of person] it's time to sit back in the lounge". We heard the person say no and staff continued to escort the person back to the lounge. No consent was sought and staff did not respect their choice of where they wanted to sit.

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. Staff we spoke to had a limited understanding of the MCA and how it affected peoples care. One member of staff said, "I have had training but I didn't understand it". Another member of staff said, "It is about assessing whether people have the capacity to answer a question and to retain what is being asked". The registered manager told us they had completed capacity assessments for all people living in the service, regardless of their capacity, with regards to taking their own medicine. We looked at one of these assessments which documented the person had capacity to understand why they needed to take their medicine. This indicated the person had capacity to understand the need to have their medicine and therefore there was no need for them to have their capacity assessed. The registered manager told us that despite training in the MCA they still did not understand the principles and thought they required further training to be able to embed the principles into their practice. We saw staff did not understand the principles of the MCA and how it affected how they delivered care and support to people The registered manager and staff did not have the knowledge or skills to ensure people received care in accordance with the Mental Capacity Act.

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

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs). We saw the registered manager had made applications to the local authority to deprive all the people living in Leighswood of their liberty and told us they felt this was in people's best interests to keep them safe. The registered manager told us they had not had any authorisations returned from the authorising body at the time of our inspection. The registered manager had not considered whether people lacked capacity to agree to their care placement when making the applications to deprive people of their liberty.

People could not share with us if they thought staff had the right skills to meet their needs. One relative told us they thought the registered manager "did their best". Staff we spoke to told us they had received training but some thought it wasn't sufficient to enable them to meet people's needs. One member of staff told us they thought they required more training on safeguarding and the Mental Capacity Act. We found the MCA was not understood by the staff team and so had not been embedded into practice. We saw one newly recruited member of staff be left alone to supervise people in the lounge. They told us they had no previous experience of care and had received no training to date.

In addition, although staff told us they had received regular training on how to move people safely; we saw numerous occasions during our inspection that unsafe moving and handling techniques were being used by the staff team. Staff were therefore not following their training and people were placed at risk as a result. We found other examples of where staff did not have the skills or expertise to support people effectively. For example, we saw staff did not ask people for consent when delivering care and were restricting people's movements around the home. We saw staff did not have adequate knowledge on how to support people living with dementia effectively. For example we saw one person display behaviour and staff did not have the knowledge or expertise to respond to them. People were put at risk of inadequate care because staff did not have the knowledge and expertise to support them effectively. The registered manager had not ensured staff had the appropriate skills and knowledge to support people.

People who were able told us they enjoyed the food. One person said, "Yes, I like the food". We saw the cook came and spoke to people in the lounge and asked them what they would like to eat. We saw people ate in the dining room or in the lounge. However, we saw the support people received to meet their nutritional needs was insufficient. Where people required support with their meals, staff were not available to provide the support they needed. For example, we saw one person who required support from staff to eat their meal. We saw they were not able to use a knife and fork and ate their food from the plate using their fingers which meant some of their food dropped on the table which they were unable to locate. Staff spoke to them but offered no support with their meal. We saw choices of drinks were offered to people at planned times twice during the day and with meals. Outside of these times we did not see drinks being offered to people. We asked staff how people accessed drinks outside of these times and staff told us they can ask if they want a drink. However, we did not see people ask or staff be proactive in offering people a drink outside of these times. We could not be sure people were supported to meet their nutritional needs.

People could not tell us if they had access to healthcare professionals when their health needs changed. Relatives gave us examples of when their family members had received visits from the doctor. One relative said, "[Name of registered manager] did get the doctor in and we had a meeting". We saw the district nurse visited on a regular basis. We saw in people's records other professionals were involved in people's care, for example, a psychiatric nurse for one person. We looked at this person's record and saw the previous visit was recorded but the staff had failed to chase up the following appointment. We pointed this out to the registered manager who chased it up immediately. We saw when people had accidents medical attention was not always sought. For example, one person is recorded as being found on the floor with a bump to

their head. We could not evidence if medical support was requested. We asked the registered manager who told us they requested for medical support when needed and they would include this in paperwork following our inspection. This meant we could not sure if all the people living in Leighswood had support to access healthcare professionals when their health needs changed.

Inadequate

Is the service caring?

Our findings

At our last inspection in February 2016 we rated the provider as 'good' under the key question 'Is the service caring?'. At this inspection we found the provider was no longer meeting the requirements of the law around respecting people's privacy and dignity.

People who were able to share their views with us told us staff did not always protect their privacy dignity. One person said they wanted to go to their room because it was too noisy in the lounge and staff told they couldn't because they were at risk of falling. They continued by telling us, "They [staff] are sharp and snappy". A relative told us, " I thought [name of person] looked a bit dishevelled last time I saw them, you know their hair looked dirty and I spoke to them about the fact they was wearing someone else's clothes". Staff explained to us how they supported people's dignity. For example, speaking to people discreetly about their personal care. However, we saw multiple examples of how staff did not promote people's dignity or privacy in particular how some staff spoke to people in an undignified manner.

We saw staff using language which did not promote people's dignity. For example, when one person asked to go to the toilet after they had just sat down to eat their lunch, the member of staff shouted, "I knew you would do that". We heard staff speak to people in an undignified way. For example, we saw one person try to talk to a member of staff about some imaginary money in their hand. The member of staff responded to the person by saying "I can't walk around with you all day again today madam. So sit back down". We saw staff did not treat people with respect by restricting their movements around the home. We saw staff held hands with people to guide them back to the lounge. Staff did not have the knowledge to understand this is disrespectful to people's human rights. We saw one person was sat in their own room with wet trousers on which smelled of urine. We brought this to the attention of staff. We saw people appeared unkempt and appeared to not have had their hair combed. We saw their skin and nails appeared unclean. People were not supported in a way that promoted their dignity. Staff did not have the knowledge to recognise when people were being supported in an undignified way. We spoke to the registered manager about this. The registered manager told us they were aware of how this member of staff spoke to people living at Leighswood but had not taken any action to prevent it reoccurring.

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

People did not always have caring relationships with staff. Relatives told us they thought staff were kind. One relative said, [Name of registered manager] has a wonderful rapport with [name of relative]". Another told us how the staff had made a cake for their relative's birthday. However, we saw staff were not always respectful or engaging when they spoke to people who lived in Leighswood. We saw staff spoke to people from a standing position and not bending to eye level when they spoke to them. Although we saw some examples of staff interacting with people in a caring way, this was not consistent across all staff. We observed people in the lounge and found they were left sitting for long periods of time with no interaction from staff. We saw one person sat with their head in their hands for almost an hour and no staff during this period intervened or asked them how they were feeling. We saw there were missed opportunities for staff to

interact with people but because they were rushed they didn't have time to spend with people. We saw people were not supported in a caring and relaxed environment. Staff had not considered people's choices of what they would like to or how they wished to spend their time. The registered manager had not recognised the staffing numbers had impacted on the quality of the care the people living at Leighswood received.

People were not always offered choices in their care. Most people could not share their views with us as to whether they were offered choices about their care or how they would like to spend their day. However, one person shared with us they would prefer to be somewhere quieter as they did not like the loud music which was playing in the lounge. They told us the noise 'drove them mad'. We asked staff about the volume of the music and they told us the music was on because one person liked to sing and dance to it and refused to turn it down. This meant that by considering one person's choice staff had failed to respect the choice of other people who lived in Leighswood. For example, we observed people having their nails painted. No choice of colour or option to refuse was offered. We saw people sat in regular positions in the lounge and therefore were not offered a choice. We saw the registered manager ask one person to move from their chair as the person they were supporting back to their chair usually sat there. This meant people did not always have a choice regarding their care or how they spent their time.

People were not involved in making decisions about their care needs. Most people were unable to share with us how they are encouraged to be involved with their care. However one person told us they were unhappy living there and didn't feel listened to. Some of the relatives we spoke to told us they had been involved with their family members care and were kept up to date with changes when they occurred. One relative told us the registered manager phoned them every week to let them know how their family member was. However, we saw staff gave instructions to people without involving them in the decisions. For example, we heard a member of staff say to one person "Now you sit here today. Do you understand?" We saw the person had not been involved in the decision. This meant we could not be sure that people were involved in their care or supported to express their views and be involved in everyday decisions about their care.

Inadequate

Is the service responsive?

Our findings

At our last inspection in February 2016 we rated the provider as 'good' under the key question 'Is the service responsive?' At this inspection we found the provider was no longer meeting the requirements of this rating.

People were not always supported to have care in the way they preferred or which was responsive to their needs. People who were able told us staff did not involve them in their care or did not respect their personal choices. For example, one person told us they were not able to go to bed at a time they chose. They continued to tell us they were woken up very early by staff which wasn't their choice. We received mixed views from relatives about being involved with their family member's care. One relative told us they had been involved in a meeting the previous week regarding their family member's care. Staff told us they thought people's preferences were not always supported by staff. One member of staff told us they thought the people living in Leighswood did not always have choices, because staff had to get people up and ready for the day staff and told us it was not always the person's choice but staff made the choice for them. However we saw there were occasions when staff recognised people's preferences as we saw one person who liked their tea from a particular china cup. We saw staff ensured that this was given to the person to enjoy their tea.

We saw people were not involved in their care and staff made choices for them without consultation with people. Whilst we saw people were offered choices we saw some people did not understand the choices available to them. For example, we saw the cook offered people a choice of food at lunch time. One person responded with, "I don't know, what's that?". We saw the cook explained to them but they still didn't understand so the cook made a choice for them. The registered manager told us they did have picture cards but could offer no explanation as to why they weren't used on this occasion. The registered manager had not ensured people were involved in their care. This meant people were at risk of receiving care which was not responsive to their individual needs.

Whilst we saw in some records that people's preferences were recorded, most records we looked at did not always contain information about people's choices and preferences. Staff told us one person's behaviour was 'unpredictable'. We looked at records for this person. No guidance was in place for staff to follow to ensure this person was cared for consistently across the staff teams. Medicine records we saw confirmed people were having creams applied at five o' clock in the morning. Staff were unable to explain to us why this practice took place. Records we saw did not always contain up to date information for staff when people's needs changed. For example, we saw one person's mobility needs had changed and records did not reflect their current mobility needs. The registered manager had failed to ensure staff had the correct knowledge and skills to identify where people's care records were not accurate and did not reflect their current care needs and individual preferences. People were not supported to have care which was responsive to their individual needs and which reflected their own choices and preferences.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People did not have access to any hobbies or interests. One person told us, "I used to walk for miles before I came here, I had a dog. Now I just sit here day in day out. There's nothing to do and no one to talk to." Staff told us they did not have time to spend doing activities with people because they were always too busy. One member of staff said, "We haven't got anyone who comes and does activities. We do what we can, but there isn't much time and there aren't enough of us to do much with them". We saw people sat for almost all of the day with no stimulation and no interaction from staff. We saw examples where staff could intervene to improve the people's day to day experiences of living in Leighswood and did not have the time to respond to people. For example, we saw one person who was picking up imaginary items from the floor. Staff did not recognise this behaviour nor did they seek to give the person anything to enhance their experience by offering any support or anything in addition to occupy their time. When people tried to engage with staff we saw staff did not have the time or knowledge to be able to communicate with them effectively. The registered manager acknowledged there were not sufficient activities for people to do and would look ways this could be improved in the future. The registered manager had failed to ensure people living at Leighswood had leisure opportunities which would support their wellbeing and meet their individual needs and preferences.

We saw the provider had a complaints system in place. Most of the people were unable to tell us if they would complain however one person told us "I used to complain I don't bother anymore". Relatives told us although they knew they could complain they hadn't because they thought the staff and the registered manager were doing their best. We looked at the complaints system in place. When people had complained we saw the registered manager had responded to their complaint and where possible action had been taken. For example, we saw a complaint had been received about the carpet in the lounge and as a result new flooring had been purchased.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2016 we rated the provider as 'requires improvement' under the key question 'Is the service well led?' This was because quality assurance systems in place were not adequate in identifying the actions required to improve the service. At this inspection we found the required improvements had not been made. The provider was not meeting the regulations around the effective management of the service.

The provider and registered manager had failed to develop an effective quality assurance system. The system in place did not identify risks to people and areas of improvement required in the service. We saw numerous areas of concern with regards to the care people received and the registered manager had failed to identify and improve the quality of the care. The registered manager could not confirm if people had received their medicines when they needed them. We saw stock levels of people's medicines did not always balance and the registered manager could not account for the anomalies. A recent audit of people's medicines carried out by their pharmacist had recommended that they have a running total of people's medicine and the registered manager had not ensured this recommendation had been implemented. We saw the system in place to monitor when people had an accident wasn't effective because the registered manager had not seen one of the reports where a person had sustained an injury and another accident we saw had not been recorded on the log. This meant the registered manager had not ensured the person was safe and protected from further harm. It also meant they did not have all the information to hand to review any trends or that the person was now safe.

The registered manager told us when they looked at trends no action had been taken to protect people to ensure accidents did not reoccur. For example, the registered manager had not reviewed staffing levels at night despite there being frequent accidents at this time which resulted in people being at risk of harm. Although the registered manager told us they were recruiting new staff as they recognised they needed more staff to keep people safe particularly on night shifts, they had not taken any immediate action to cover where more staff were needed. We saw the environment was not considered as part of the quality process. The system did not recognise people were not offered choices or involved in their care. We saw the décor around the home was tired and in need of some redecoration. For example the lounge was stark and contained no colours or ornaments to stimulate people living with dementia. We saw some audits had recognised where improvements were required and noted that action had been taken to rectify the issues. For example, following concerns highlighted by the fire service the fire safety audit had highlighted where improvements were needed and the provider had taken action to ensure the building was safe following their recent inspection. However we found people were left at significant risk of harm because of the overall failures in the quality assurance system.

We identified a number of concerns about the care practices of staff working at Leighswood. The registered manager was aware of the poor behaviour of one member of staff but had failed to take any action to address this and ensure people were protected from the risk of harm. The quality assurance system also did not identify when people were at significant risk of harm due to unsafe moving and handling techniques being used by staff, despite them having received training about how to move people safely. We identified

serious concerns in the competency of the registered manager. We saw when poor practice was taking place no action was taken by the registered manager to rectify poor staff practice. For example, we saw staff moved a person using a technique which may cause harm; the registered manager was stood next to them and took no action to correct the member of staff.

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

We received mixed views from relatives and staff about whether the home was well led. Relatives all told us they thought the staff and the registered manager did their best but had concerns about the care and staffing levels at the home. One member of staff told us, "The home is not well led. If it was my mum I would want better for her. I would not want my mum to live here". We could not see how the registered manager involved people and staff in the running of the home. Staff had raised concerns with us prior to our inspection about the effectiveness of the registered manager. Some staff told us they were supported by the registered manager and had regular supervisions and team meetings. One member of staff said, "We talk about anything in supervisions. We discuss any changes in the team meetings" However another member of staff told us although team meetings were planned they were often cancelled. Staff told us that a positive culture wasn't always present and that differences between how day and night staff communicated meant they didn't always work well together as a team. We saw the registered manager had not addressed these concerns which had resulted in a negative culture within the home. We saw tables in the dining room had not been cleaned appropriately and pointed this out to the registered manager. The registered manager told us, "It's the night staffs fault not mine." This indicated to us that the registered manager did not encourage the staffing team to work together to promote a more positive culture within the home. This also demonstrated they did not take responsibility as the registered manager for all the staff working in the home. Some staff were satisfied with their support in their role but improvements were needed to improve the culture within the home.

We spoke with the registered manager about how they were supported in their role. They told us they did not receive sufficient support from the provider. They told us they had not had any form of supervisions as to how they were progressing in their role. Staff were aware of the whistleblowing policy and felt they could raise issues with the registered manager. We also saw that the provider had ensured information about the service's inspection rating was displayed as required by the law. We found the provider had met their legal requirement in submitting notifications to CQC. The provider was aware they were required to notify us of certain events by law such as allegations of harm or abuse, and they had done so.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide person centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect (1)The provider had failed to ensure that service users were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent (1)The provider had not ensured that care and treatment of service users must only be provided with the consent of the relevant Person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (a) The provider had not ensured risks to the health and safety of service users were assessed so they were in receipt of safe care and treatment. (b) The provider had not ensured they had done all that is reasonably practicable to mitigate such risks. (g) The provider had not ensured the proper

and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1)The provider had not ensured there were sufficient numbers of suitably qualified, competent skilled and experienced staff deployed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance a)The provider had failed to assess, monitor and improve the quality and safety of the services provided. (b)The provider had failed to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk.

The enforcement action we took:

Agreed in MRR1-3514788229 AS PROVIDER HAD FAILED TO MONITOR THE SERVICE.