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

Summary of findings

Overall summary

This service was placed in Special Measures following our inspection in January 2017. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The overall rating for this service is 'Inadequate' therefore the service will remain in special measures.

This inspection took place on 26 and 28 July 2017 and was unanounced. Leighswood provides accommodation for people who require personal care for up to 23 people. At the time of our inspection there were 18 people living there.

We last inspected this service on 31 January 2017 and again on 01 June 2017. At our Inspection in January we found the provider was not meeting the requirements of the law in six areas and we rated the provider as inadequate in each of the five key questions. We spoke with the provider's representative and the registered manager following our inspection in January 2017. We asked them to send us an action plan detailing what actions they would take to improve the service. We issued a warning notice due to the failure in the governance system at Leighswood.

Following our Inspection in January 2017 the registered manager left the service. At the time of this inspection the provider had appointed a new manager who had not at the time registered with CQC. 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.

We completed a focused inspected on 01 June 2017 to see if improvements had been made. At this inspection we found improvements had been made, but we did not change the rating as we only inspected under one key question 'Is the service safe?' We completed a comprehensive inspection in July 2017 which looked at all five key questions. At this inspection we found improvements had been made in some areas. We found people were now treated with dignity and respect by staff and we found there were sufficient staff to meet people's needs. We found people's rights were protected through effective use of the Mental Capacity Act and people were now receiving care which met their individual needs. However, we also found the provider was not now meeting the requirements of the law in two new areas. We found the provider was not providing safe care because we could not be assured people got their medicines as prescribed and the recruitment system operated by the provider had not ensured people were cared for by staff who were appropriate to provide care to people who used the service. The governance system operated by the provider had not improved sufficiently which meant the terms of the warning notice had not been met and they were still not meeting the requirements of the law.

Although people told us they felt safe we found improvements were still required in how people received

their medicines and how staff recorded when people were offered their medicine. The provider did not operate a safe recruitment system which meant people were at risk of receiving care from staff who were not suitable to provide care to the people living in Leighswood. We saw safe techniques were used to move people. Staff understood the risks to people's health and safety and how to manage them; however these were not always recorded in their care records. There was sufficient staff to meet people's needs. Staff understood their responsibility to raise concerns regarding potential abuse.

Although people told us staff had received training to support them we found improvements were still required in some areas. Staff we spoke to told us they had received training which helped them to support people with safe care but there were gaps in staff knowledge with regards to the Mental Capacity Act (MCA) as staff had not received any training in this area. Staff understood the need to ask for consent and we saw they sought consent before providing any care. The manager had applied the principles on the Mental Capacity Act. People's nutritional needs were being met. People had access to other health professionals when their health needs changed.

Although people told us they were supported by kind and considerate staff, we found the provider was not always caring in their approach to the care people received. People had choices about their care and staff listened to them and respected their choice. People were treated with dignity and respect by staff. Staff encouraged people's independence where possible.

People and their relatives told us they felt comfortable raising complaints with the manager, however there was not a formal complaints process in place. People received care which was responsive to their individual needs and had choices about the care they received. Some improvements were required to ensure people's care records contained up to date and accurate information about the care they received.

The governance system in place was not effective as it did not highlight the areas where we found concerns during our inspection. Although people told us they were happy with the care they now received and recognised there had been marked improvements since our previous inspection we could not be assured this was sustainable as there was no oversight of the service by the provider and there was no registered manager at the service. Staff told us they were supported in their role.

During this inspection we found 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 the report.

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.

Improvements were required in the management of people's medicines. People's risks were not always assessed and recorded in their care plan. The recruitment system in operation did not ensure staff were safe to work with vulnerable adults. There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff told us they had not received training in the principles of the Mental Capacity Act therefore people could not be certain their rights would be upheld. Staff obtained consent from people before providing care. People received care from staff who had been trained to meet their needs. People's nutritional requirements were being met. People received support from other healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider was not always caring because improvements were still required in some areas of the service. People received support from staff who were kind and considerate. Staff respected people's choices and treated people with dignity and respect. People's independence was encouraged where possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People told us they felt comfortable in raising concerns with the manager. There was no formal complaints system in place. Although people told us and we saw people received care that was responsive to their individual needs, improvement were required in the recording of peoples care in their records.

Is the service well-led?

Inadequate

The service was not well-led.

The governance system in place was not effective as we highlighted areas where improvements needed to be made. The provider had no oversight of the service. People told us there had been improvements in the management of the service and felt there had been improvements in the care they received. Staff felt supported in their role and there was now a positive culture within the service.

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 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 28 July 2017 and was unannounced. The inspection team consisted of two inspectors, one of which was a pharmacy inspector, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. In this case their area of expertise was caring for someone with dementia.

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 also contacted the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

We spoke with five people who used the service and three relatives. We spoke with the provider, the manager, 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 three people and medicine records for nine 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 manager.

Inadequate

Is the service safe?

Our findings

At our inspection in January 2017 we found the service was not safe and we rated the provider as 'Inadequate' in this key question. We found risks to people's health and safety were not safely managed. This was because unsafe moving and handling techniques were used; systems were not in place to ensure people got their medicines as prescribed or when needed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found there were insufficient staff to keep people safe and to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We inspected the service again in June 2017 and we found improvements had been made and they were now meeting the requirements of both of the above regulations. At this inspection, we found whilst improvements had been maintained in relation to regulation 18 we found other areas where improvements had not been maintained and the care people received had deteriorated due to the management of their medicines. The provider was now not meeting the requirements of the law with regards to regulation 12. At this inspection we also found the provider was not meeting the requirements of the law with regards to staff recruitment.

We looked at how medicines were managed. We found recording issues with the administration records for some oral medicines which meant we could not be sure these people had received their medicines as prescribed. Staff had failed to complete medicines records accurately. We found gaps in records where staff should sign when people's medicine has been administered. We also found examples of where the administration records had been signed to confirm administration had taken place. However, we found the medicines had not been administered. We found the provider had not established strategies for those people who were refusing their medicines or were asleep during the medicines rounds to ensure their medicines were administered as prescribed. For example, we saw a person had refused one of their prescribed medicines on nine out of a possible 15 days and their doctor had not been consulted about the risks posed to this person.

We found medicines that had been prescribed on an 'as required' basis had written information in place to support staff about when and how these medicines should be administered. Although we saw a member of staff administer one person's medicine in line with their individual guidance, this was not consistent as we also found a person was receiving their 'as required' medicine when there was little written evidence that the person required it.

Although we found some improvements had been made in the management of people's medicines, for example, we found topical medicines were now being applied in accordance with the prescriber's instructions we found the provider had not ensured staff had the right skills and knowledge to ensure people got their medicines as prescribed.

We also found some medicines were not always being stored securely for the protection of people using the service. For example, we found topical medicines were being kept in people's rooms and therefore people using the service could inappropriately use these products.

Where people had risks to their health and safety we found the provider had not ensured risk assessments were in place for staff to manage their risks safely. For example, one person was at risk of skin damage. We looked at this person's care records and found there was no assessment in place and therefore staff did not have clear instructions on how often they should support this person to move to prevent further skin damage. Staff we spoke to gave us different opinions of how often this person should be moved. The manager confirmed with the healthcare professionals who also supported this person with the management of their sore skin that there was no further deterioration in their condition. The manager told us they had made the decision to support this person to move every half an hour. Records we saw confirmed this person was being moved every hour and a half. The provider had not ensured risks to people's health and safety were being assessed and guidance in place for staff to follow.

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

At the inspection in June 2017 we did not look at the recruitment system in place because at the inspection in January 2017 and we found the provider operated a safe recruitment system. At this inspection, we found the provider had failed to maintain this safe system and they were now no longer meeting the standards required by law. We looked at four staff files and found in three of them documents had not been requested to ensure the person's correct identity prior to commencing their employment. We also found references had not always been requested from staff member's previous employers and when references were present we could not be assured who had provided them. We saw one person's application form had not been fully completed and there was no application form on another person's file. We saw one person had begun their employment prior to the provider having received their disclosure and barring (DBS) check. We saw on another staff file the DBS check was from a previous employer and no further check had been completed by the provider. DBS helps employers to make safer recruitment decisions and prevents unsuitable people being recruited. We saw on two staff members' records positive disclosures had been identified on the DBS checks and the provider had not taken any additional measures to ensure they were safe to work in the service. The provider had no oversight of the recruitment system and had not ensured recruitment practices were safe and staff recruited were safe to work with people living at Leighswood.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper person's employed.

At our inspection in June 2017, we found improvements had been made to the staffing levels at Leighswood. At this inspection we found this had been maintained. People and their relatives told us staffing levels had improved since our previous inspection in January. One person said, "There's always someone around to help me if I need them. If I ring my buzzer now at night they are here in a flash. I used to have to wait such a long time". A relative commented, "You always see plenty of staff around now. Not like before". We saw staff were available when people required extra support. We saw staff had time to spend with people engaging in conversations and supporting people with puzzles or reading. At our inspection in January we saw people were restricted in how they moved around their home and were directed back to the lounge. At this inspection we saw people walked around the home freely without staff directing them back to the lounge. The provider had ensured there were sufficient staff to meet the needs of the people living at the service.

At our inspection in January 2017 we saw when people had accidents the provider had not ensured action was taken to prevent the accidents from reoccurring. At this inspection the manager told us they were monitoring when people had falls to prevent any further occurrences. People told us they had not fallen as frequently as they had before and staff confirmed what people told us. We saw there had been fewer accidents and where people had fallen action had been taken to ensure the risk of it reoccurring had

reduced. For example, staff told us they had moved one person's furniture in their bedroom to allow more space for them to walk.

People and their relatives told us there had been improvements in how they were cared for which meant they now felt safe. One person said, "There have been some great changes around here. I have a new piece of equipment. Being moved feels so much safer. I can't say I did before". Another person said, "I'm safe. They keep me safe at night especially. I used to fall a lot but haven't had one for ages you know". Relatives we spoke with all told us they felt their family members were now safe because of the improvements in staff training and in staffing levels. We saw people were supported by staff safely when being transferred. We saw one person who had sight loss was supported by staff appropriately. For example, we saw staff gave this person guidance as they walked to ensure they remained safe.

People now told us they felt safe and staff understood how to recognise signs of potential abuse and how to protect people from harm. One member of staff told us, "We look for changes in behaviour or physical signs such as bruises". Staff told us they now had the confidence to approach different managers within the organisation if they thought people were at risk of unsafe care. Staff told us they would not hesitate in going above the manager or to organisations outside of the home such as the police or CQC if they identified any such concerns. One staff member said, "I would whistle blow now. It's our duty of care for them". We saw the manager had raised any concerns with the local authority when they suspected potential abuse.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2017 we rated the service as Inadequate in effective. The registered manager at the time of the inspection in January 2017 had failed to apply the principles of the Mental Capacity Act and had failed to ensure the staff had the knowledge and skills to ensure people received effective care and consent was not always sought. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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. At this inspection we found improvements had been made in these areas and the requirements of the law were now being met. However, these were recent improvements that need to be sustained.

At our previous inspection we found staff did not seek consent from people before providing their care and when people refused support, staff continued and did not respect their choice. Staff now told us the new manager had ensured they understood the principles of obtaining consent from people and how this affected people's care. We saw staff asked for people's consent before providing any care and respected people's choices. For example, we saw staff asked people where they would like to sit, and when they responded staff acknowledged their choice and supported them to sit where they chose.

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 told us they had not received any recent training in how the principles of the MCA and how it affects people's care. The manager told us they had not received training recently but told us all people living at the home had capacity to make decisions about the care they received and could consent and make choices about their care. For example, the manager told us about how they had respected a person's choice not to go to the dentists as they preferred to put up with occasional pain than the dentist pull their tooth out. We spoke to this person who confirmed they had chosen not to go to the dentist. Records we saw with regards to staff training indicated some staff had not received any training in this area for several years. Therefore we could not be assured people's rights would be upheld due to the lack of knowledge of some staff. The manager told us they would be arranging MCA training for staff following our inspection to ensure staff had the knowledge and skills to provide effective care to the people living in the service.

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). The manager told us that at the time of this inspection they were not depriving anyone of their liberty. One person told us, "I feel happy now because I can go outside and have a walk. I can go where I want either in here, there or anywhere". The manager explained if people wanted to go out they were supported by staff if required and were free to go for a walk around the garden if they chose and no one had expressed an interest to go beyond this by themselves.

People and their relatives told us staff had received more training since our last inspection and thought they had the skills and knowledge to meet their needs. One person told us they now felt safe because staff had received more training. A relative commented, "I'm in no doubt about their training now because [Name of Person] is much cleaner and happier". Staff also explained how they had received training to help them provide safer care to people. One member of staff said, "We get a lot more training now. I know now that I am doing it right. I know how to walk with someone safely. It was bad before we hardly had any training". Another member of staff told us how the training they had received on end of life care had helped them approach families better and understood what to talk about with them. We saw staff moved people safely and provided support to people who needed it to walk around the home safely. We saw staff understood how to support people up from their chairs safely without an increased risk of injury. However, records we saw demonstrated there were areas where some staff had received no recent training in areas such as MCA and dementia care. The manager was aware of this and was taking steps to organise further training for staff. We spoke to newly recruited staff who told us the induction they received helped them get to know the people and understand their needs. They told us they shadowed staff to learn about people's needs before starting to work alone. People were supported by staff who had received some training to meet their needs.

People were supported to have their nutritional needs met. People told us they enjoyed the food and had choices about what they ate. One person said, "We have a lot of choices. It is even better now we have a new chef. There's a good variety". Another person said, "Do you know we never had fresh fruit before but now we get oranges, apples, strawberries and my favourite, bananas". We saw staff were available when people required support to eat their meals and choices were offered to people. We saw people had a choice of where they would like to eat their lunch and we saw staff took both food options available to people who chose to eat in their rooms so they could make a decision based on what they saw. We saw some people had adapted crockery to help them remain independent when eating their meal. We saw condiments were available for people and staff offered visual choices of the meal where people may find it difficult to make a decision. One person told us, "They come round on a morning and ask what you want and if we forget they remind us, but we can have what we want". We saw drinks were available all day for people and staff prompted people throughout the day if they wanted another drink, both hot and cold drinks were offered to people. We spoke to the cook who knew people's choices and preferences and told us the people who had restrictions on their diet for health reasons.

People and their relatives told us they had access to other care professionals when required. One person told us," If I feel a bit unwell and I'm worried about it, the staff will ring the doctor. When I was really unwell in the night once they got the paramedics. They are brilliant". Relatives confirmed what people had told us. One commented, "If [Name of person] is at all off colour or unwell they just ring the doctor. When they were unwell the other week they just fetched the doctor. Things are much better now". We saw the manager involved other professionals such as the district nurse and specialist nurses in people's care when their health needs required additional support and they visited the home on a regular basis.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2017 we rated the provider as Inadequate in caring. This was because 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 and staff spoke to people in a disrespectful way. We saw people appeared dishevelled and unkempt. Positive relations were not always developed between staff and people who lived at the home. People did not always get choices with regards to how their care was delivered. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made in these areas and the provider was now meeting the requirements of the law.

Although we saw individual care staff were caring and provided care which met people's needs, we also found the provider had not ensured the care people received was safe, effective and responsive to their individual needs and therefore we could not be assured the provider was caring in their approach to people's care. For example, we found the provider had not ensured people were receiving their medicines as prescribed. We asked the provider how they had ensured people were now in receipt of safe care. They told us they had seen people appeared happier but had not been involved in the running of the service and had no systems or oversight to ensure people were well cared for.

People and their relatives told us the staff were kind and caring and treated them with dignity and respect. One person said, "They're lovely. They're so kind and always respectful. It's a much happier place these days. I don't know what I would do without them". Another person told us, "The girls are so very good. Salt of the earth. Nothing is too much trouble. They are really kind". Relatives confirmed that staff were kind and respectful. One relative commented, "The girls are wonderful. They are very respectful and helpful".

We saw the manager and staff involved people in their care. People told us they were happier and more content living in the service. Staff told us they had involved people as much as possible in the redecorations we had taken place in the service. They asked people about the colours of paint they preferred and which furniture they liked. One person told us, "It's really great now. I like it in here and in the garden. I feel happy because I can go outside and have a walk or a smoke when I want. I can go where I want either in here or in there or anywhere." One member of staff told us they knew how most people chose to spend their days and what they liked to do. The layout of the rooms where most people spent their time had been altered to allow different spaces for people to sit and they could then chose to watch television, listen to music or just spend quiet time alone. We saw staff offered people choices about their care which meant people were happier and more relaxed in the service because they were involved in their care and staff listened to them.

Staff knew people well and we saw positive relationships had developed between people and the staff who supported them. For example, we saw one person who was nursed in bed with their eyes closed. However when a member of staff came into the room to enquire if they needed anything the person on hearing the member of staff's voice, opened their eyes and their face lit up into a big smile. The member of staff reached out their hand spontaneously and exchanged smiles with the person. We saw people appeared clean and better cared for. We saw people were dressed in clean clothes and people's individual choices were

respected by staff. We saw staff treated people in a way which promoted their dignity. For example, we saw staff bent down to speak to people at eye level and use endearing terms as well as touch which we saw made people feel at home. We saw people were offered choices and staff respected their choices. For example, we saw people now had a choice of where they would like to sit to watch television, listen to the radio or sit quietly in the conservatory. People were now involved in making decisions about their care and were supported by kind and caring staff who listened to them and treated them with dignity and respected their choices.

We saw staff promoted people's independence where possible. For example, we saw people were encouraged to walk and had gained more independence since our last inspection. A member of staff told us, "We prompt [Name of person] to wash their own hands. We don't want to take their independence away. We are here to help, not to do". We saw relationships that were important to people were now encouraged. We saw relatives visited more frequently and one person told us they now went out regularly with their family. Relatives told us there was a better atmosphere in the home and it was cleaner and felt more homely. One relative commented, "I visit my relative much more often now. Sometimes I have a meal. I feel happier going there now. I just didn't like to see how awful it seemed to be. There are no restrictions about people visiting any time of day or night".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2017 we rated the provider as Inadequate in responsive. This was because people did not have care which was responsive to their individual needs. People did not have choices about their care and were not involved in making decisions about how they preferred their care to be delivered. We found people did not have access to activities of their choice. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and they were now meeting the requirements of the law in this area. Although improvements had been made since our inspection in January 2017 we found there were still areas where improvements needed to be made. We found at this inspection they were not now reaching the standards required by law with regards to acting on complaints.

People told us they were happy with the care they received and relatives commented they found the manager approachable and felt they would be listened to should they need to complain. We saw one relative had complained and the manager was addressing their concerns. The manager told us there was no formal complaints process that they were aware of and they had ensured there were forms left out for people should they wish to make any suggestions. We saw there was nothing to inform people how to complain and what to expect when they did. Although the manager told us they would look into introducing this in the future, the lack of a formal complaints system meant we could not be assured complaints would be responded to appropriately.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

At this inspection, we found staff gave people choices about their care. One person told us, "They always listen to me and ask what I want. I like a bath. I've had one today". Staff understood people's needs and preferences and were able to tell us how people preferred their care. People told us they could choose when they got up and when they went to bed. We saw some people remained in bed throughout the morning of our inspection and we saw staff respected people's choices of how they wished to be dressed throughout the day. One person who chose to remain in their room told us staff always asked if they preferred the door open or closed and we saw staff respected their choice. We saw staff communicated with residents in ways which were meaningful to them. For example, we saw a member of staff involve themselves in the imaginary world of a person. The member of staff understood the person and engaged in conversation about this person's imagination and thoughts which left the person feeling more relaxed. We spoke with a visiting professional following our inspection who told us one person's challenging behaviour had reduced and they told us they were calmer. They explained they thought this was due to the fact staff had more time to spend with them.

Records we looked at contained some information about people's choices and preferences. For example, we saw one person's favourite food was recorded which the person confirmed and staff were aware of their choice. However we saw areas where care plans could be improved and more person-centred information added. We saw examples of where care plans did not reflect up to date care for the person. The manager

told us they were working on this currently. The manager acknowledged there were areas where improvements could be made but told us they had been concentrating on the care people received as a priority and then would be personalising care records.

We saw people now had access to activities. One person told us, "The girls take me to the shops to buy bits I want or we have a walk to the allotments and we've been to a show. I go down the garden to read my books and have a chat with my friends". Another person commented, "There's more things to do here now. We go out more, play games, do jigsaws, quizzes, music and movement and watch films". Staff had time to spend with people and we saw staff supported people to complete jigsaws. We saw a member of staff spent time with a person quietly in the conservatory reading and looking at photographs. We learnt this was a technique staff used to calm the person if they were feeling agitated and by looking at their favourite pictures calmed them down. We saw people had access to the garden and regularly went outside for a walk. We saw people joining in with exercise to music session and all appeared to enjoy themselves as we saw them laughing and joking with each other whilst joining in. We saw there had been improvements in the lack of activities seen at our previous inspection. Whilst we saw more activities were available for people the manager told us they were working on providing more personalised activities in the future.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2017 we rated the provider as Inadequate in well led. This was because there was no effective governance system in place. We found the provider had relied on the registered manager to run the service and had no oversight of how the service was being run. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection we issued a warning notice to the provider which gave them a date in which they were required to improve their governance system to ensure people got safe care. At this inspection we found some improvements had been made in the governance system but these were not sufficient to meet the requirements of the warning notice. We found the provider still had no oversight of the service since our inspection in January 2017. Following our inspection in January 2017 the registered manager resigned from their post and cancelled their registration with CQC. The provider employed a new manager in April 2017 to oversee the service. At the time of this inspection the manager had not yet registered with CQC but told us they would be applying following our inspection, which they did. However, the service does still not have a registered manager; the provider has no oversight of the service and in some areas the care people received had deteriorated. Therefore the service will remain in special measures.

Although we found there had been some improvements in the care people received, we found two new areas where the provider had not ensured they were meeting the standards required by law. We found insufficient improvements had been made in the governance system and people's risks were not recorded in their care plans. We found the manager had recently introduced an audit process to check on and promote improvements with the management of medicines. We found the audit process was not robust enough to ensure discrepancies with the medicines were identified and dealt with in an effective manner. We found the provider had relied solely on the efficiency of the manager and still had no oversight of the governance of Leighswood. This was further demonstrated by the recruitment system in place as the provider was not aware of the DBS disclosures and the lack of documentation that had been requested and secondly by the lack of a complaints system within the service.

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

Throughout our inspection people told us the new manager had made improvements and as a result they were happier and safer now. One person said, "I've lived here for years and it's never been so good". Relatives were enthusiastic about the changes which had been brought about since the new manager started. One relative told us, "The staff talk to us now and the new manager has made a big difference to this place. They pop in to see us. They are very approachable; I know I could talk to them about anything". We saw people were happier and spent more time laughing and joking and engaging in positive conversation both with staff and each other. We saw the environment had improved since our previous inspection and some people's rooms had been painted as well as the lounge and dining room. We saw the layout of the downstairs had changed which meant people had more space to walk about and more areas for people to choose to sit. People now received care which was individual to their own needs and had access to activities

to spend their time. However, due to the lack of oversight by the provider and the lack of a registered manager in the service we could not be assured these improvements were sustainable.

Staff told us they were now supported in their roles and now felt there was a better culture within the home. One member of staff commented, "It's getting better. A lot better. The staff are happier and as a result the residents are happier". Staff told us they would now recommend the home to their relatives because the care had improved. The manager told us they had involved people in the running of the home and had had a recent meeting with people to discuss what meals they would like on the menu. This had resulted in more choice on the menu being offered on an evening. We saw both people and staff had been given the opportunity to complete questionnaires to comment on how they thought the service was run. The results were all positive. The provider had ensured the home's rating was displayed both in the home and on their website. The manager understood their responsibility to inform CQC of events which had occurred such as safeguarding notifications and had done so when required.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no formal complaints system in place.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not get their medicines as prescribed. Risks were not always recorded in people's care records.

The enforcement action we took:

We issued an Notice of Decision to add a positive condition to their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had no oversight of the service and some areas of people's care had deteriorated.

The enforcement action we took:

We issued a Notice of Decision to add positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have a safe recruitment system in place.

The enforcement action we took:

We issued a Notice of Decision to add positive conditions.