Quality Homes (Midlands) Limited

Leighswood

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

This focused inspection took place on 1 June 2017 and was unannounced. The inspection team consisted of two inspectors, one of which was a pharmacy inspector. Leighswood is registered to provide personal care and accommodation for up to 23 people. There were 18 people using the service at the time of our inspection.

At the last comprehensive inspection on 31 January 2017 this service was placed in special measures by CQC. At that inspection we had found breaches of six regulations in which two of these were in relation to the key question, 'Is the service safe?' The rating of inadequate was given to this key question. This was because risks to people's health and safety were not being managed safely, people did not get their medicines as prescribed, people's freedom of movement was restricted and there was insufficient staff to meet people's needs. The overall rating for this service was 'Inadequate'.

This report only covers our findings in relation to the breaches we found under the key question, 'Safe'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Leighswood on our website at www.cqc.org.uk.

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

Since our last inspection on 31 January 2017 the registered manager had left and the provider had recruited a new manager but they had not yet registered with the Care Quality Commission. 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.

At this inspection we found some improvements had been made but further improvements were still required. The provider was no longer in breach of the two regulations in relation to the key question we reviewed. The overall rating for the service remains 'Inadequate'.
People and their relatives told us there had been improvements and said they now felt safe. Staff told us following our last inspection they had received training in how to move people safely. We saw people were now being moved using safe techniques. However, the provider was unable to demonstrate the hoist used to transfer people was safe and action was taken to address this.

People told us they got their medicines when they needed them. We found improvements were still needed to record when people had skin patches or prescribed creams applied. Records did not demonstrate what action staff took when people regularly refused their medicine. We found when people were prescribed their medicine 'as and when' some people were given it on a regular basis, and further guidance had not

been sought. Although some improvements had been made we found further improvements were required to ensure people got their medicine as prescribed.

People told us there were sufficient staff to meet their needs. We saw staff were available when people required any support and staff were available to spend time with people. The manager told us they had now considered the staffing levels on a night time and told us there were sufficient staff to meet people's needs due to staffing being deployed appropriately.

We will review our rating for 'safe' at the next comprehensive inspection to make sure the improvements made continue to be implemented and embedded in to practice.

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 always safe.

People were moved using safe techniques. We could not be assured equipment used to transfer people was safe and action was taken to address this.

People did not always get their medicine as prescribed. Improvements were needed in the recording of people's medicine.

There were sufficient staff to meet people's needs.

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 quality of the service in respect of one key question area.

We undertook this focused inspection of Leighswood to review whether people received a safe service. This inspection was conducted to assess whether improvements had been made to meet specific legal requirements, following our inspection on 31 January 2017. We inspected the service against one of the five key questions we ask about people's care: 'Is the service safe?' This inspection was unannounced and was conducted by two inspectors one being a pharmacy inspector.

After our previous comprehensive inspection we met with the provider to discuss our concerns about the service and to hear about the improvements they planned to make. They also wrote to us saying what they would do to meet legal requirements in relation to the six breaches of regulation.

We asked the local authority if they had any information to share with us about the care provided by the service. As part of our inspection we also checked any notifications the provider had sent us since our last visit. Notifications are reports of events and incidents the provider is required to notify us about by law, including unexpected deaths, safeguarding matters and injuries occurring to people receiving care. In addition we reviewed information the information the provider had sent us following our last inspection. This information helped us to plan our inspection.

During the inspection we met and spoke with the new manager and the provider. We spoke with six members of staff and two people who used the service and two of their relatives.

Inadequate

Is the service safe?

Our findings

At our last inspection on 31 January 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified specific issues relating to the management of peoples risks, particularly with regard to moving and handling people and medication management. At this inspection we found that the provider was no longer in breach of this regulation but further improvement was still required.

Staff told us they had received training in how to move people safely and how to use the hoist and the new manager had completed spot checks to ensure they were using the equipment correctly. We saw people were supported by staff safely around the home. Equipment was now available to support people who had been assessed as requiring equipment to move them safely. Although we had been told the equipment had been serviced to ensure it was safe to use, the provider was unable to produce documentation to confirm this. Following our inspection the provider informed us they had purchased a new hoist which ensured people who required it were moved safely. Although staff had the knowledge to support people with their risks we saw improvements were needed in how they were recorded. The manager told us they were working on the documentation but they had prioritised the need for staff to have the skills to keep people safe first.

People who were able told us they got their medicine when they needed it. One person told us, "They check I have my tablets. One a day". Another person told us, "They bring my medicine for me". We reviewed the management of medicines, including the Medicine Administration Record (MAR) charts for six people. Although some improvements had been made, we found medicines were not always managed safely. Medication administration records were incomplete so it was not possible to tell if people had received their medicines as prescribed. The manager told us they had witnessed cream being applied but accepted they weren't always recorded appropriately.

Some people regularly refused their medicines. However no guidance was available for staff to advise them of the actions to take to support people to take their medicines appropriately. We looked at the records for people who were using medicinal skin patches which showed where the patches were being applied to the body. We found patches were not being applied and removed in line with the manufacturer's guidance. This could result in unnecessary side effects. We discussed our findings with the manager who agreed improvements needed to made and would ensure staff got further training.

When people had been prescribed medicines on a 'when required' basis we saw staff did not always follow instructions. We saw two people were regularly being given these medicines however staff had not recorded why they had been administered or requested a doctor to review their frequent use. We observed staff explained to people what their medicines were for and gave them the time that they needed to take their medicines safely. Medicines were stored appropriately. The manager advised that they were receiving ongoing support from a member of the Clinical Commissioning Group (CCG).

At our last inspection on 31 January 2017 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of sufficient staff during the night to meet people's needs. People's rights to choose where they wanted to be in the home were restricted because staff directed them into the lounge as there were insufficient staff to keep them safe elsewhere. At this inspection we found improvements had been made in line with the action plan the provider sent following our previous inspection and the provider was no longer in breach of this regulation.

At this inspection people told us there was sufficient staff to meet their needs. One person said, "There is enough staff. Staff come when you need them". Relatives told us they thought staffing levels had improved and were happy that their family members were now getting the care they needed. One relative said, "[Name of person] is not having any falls now and no bruises". Another relative told us, "[Name of person] gets everything they need, when they need it". Staff told us new staff members had been recruited and this meant more staff were available to support people. We saw staff were available when people required support. We saw staff had time to spend with people when they required support or reassurance.
The manager showed us they had used a staffing tool to look at people's individual needs particularly during the night to determine how many staff were required. We spoke to some night staff during this inspection who confirmed the redeployment of night staff meant there were now sufficient numbers to meet people's needs safely. We saw there were enough staff available to support people when they chose to move freely around the home. We saw staff were available to support people and people were no longer prevented from moving around the home freely. We saw people leaving the lounge and choosing where to sit or where to spend their time. We saw staff supported them to do and go where they chose without redirecting them back to the lounge.
Accidents and incidents were documented and being reviewed by the new manager. We saw accidents had reduced since our previous inspection and the manager was taking action to prevent further occurrences. For example, when one person had fallen from the bed the manager had taken action and had lowered the bed to prevent this happening again. The new manager told us they had obtained equipment such as slide sheets to prevent further injuries.

People told us they felt safe. One person said, "I feel more contented now than I did. Staff before were sharp and grabbed me. I feel safe now". Another person told us, "Yes I feel safe". Relatives confirmed what people had told us, one relative said, "I think [name of person] is safe now, but they weren't before". Staff understood how to keep people safe and had the knowledge and skills to protect people from harm.

At our previous inspection in January 2017 we found the provider had a safe recruitment system in place so we did not look at this area at this inspection.