Homebeech Limited

Homeleigh

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 May 2016 and was unannounced.

Homeleigh provides accommodation, support and nursing care for up to 38 older people. At the time of this inspection, there were 25 people living at the home, nine of whom were living with different stages of dementia.

A registered manager was in post when we visited. 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.

The current registered manager was appointed in December 2015 following the retirement of the previous manager. One senior member staff had also chosen to retire, and two staff have been absent due to sickness for an extended period of time. This meant that a large number of staff have had to be employed on a temporary basis via employment agencies to ensure appropriate staffing levels have been maintained. Whilst the provider and registered manager have demonstrated they have been taking steps to recruit new staff the evidence gathered during this inspection has indicated that the number of current staff vacancies has had an impact on the provision of care.

Not all staff had received up to date training to ensure they had the necessary skills and knowledge to provide care effectively to meet the needs of people accommodated.

We observed mixed experiences of people being treated with dignity and respect. Some staff on duty were seen to be kind and caring towards people accommodated. However, we also observed examples where staff practice did not always respect people's right to privacy and dignity. For example, we saw staff entering people's rooms to clean even though they were in bed and asleep.

People living with dementia and people who were cared for in bed were not provided with sufficient activities to ensure they were not a risk of social isolation.

People had not always received person centred care. For example, the needs of one person with a sensory impairment had not been met. The support provided to some people required was not sufficient to ensure they had enough to eat and drink.

Medicine Administration Record (MAR) sheets had not been kept up to date to confirm medicines had been administered as prescribed. Medicines had been stored safely.

People said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything.

Care plans had been drawn with the involvement of people and their families.

The registered manager understood the principles of the Mental Capacity Act 2005 (MCA), the Deprivation of Liberty Safeguards (DoLS) and how they affected their work. These safeguards protect the rights of people by ensuring if there were any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm.

Newly appointed staff told us they felt well supported by the registered manager. They had been provided support and assistance during induction to help them understand their role. The registered manager had set up a programme of supervision for all staff to ensure they received the support they needed.

The registered manager had arranged meetings with people and their relatives meetings to enable people to express their views and to be involved in making decisions about the service.

A written complaints procedure was in place that showed that, where concerns or complaints had been raised, the registered manager would respond to them on an individual basis in writing.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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?

Requires Improvement

The service was not always safe.

Identified risks to people had been managed safely to reduce the likelihood of recurrence.

Records related to the administration of medicines had not always been accurately and appropriately maintained to ensure they had been managed safely.

Staff understood the importance of protecting people from harm and abuse.

There were enough staff on duty to deliver care to people at the times they wanted or needed. However, due to vacancies, a large number of staff had been employed from agencies.

There were enough staff on duty to deliver care to people at the times they wanted or needed. However, due to vacancies, a large number of staff had been employed from agencies.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received appropriate refresher training to enable them to provide care skilfully and effectively in accordance with current guidance and practices.

When people did not have the capacity to consent to care and treatment, suitable arrangements had been made to ensure decisions were made in their best interests. Deprivation of Liberty Safeguards (DoLS) applications to deprive people of their liberty had been made lawfully to ensure people's rights were protected.

People were supported to have sufficient to eat and drink.

People had access to community healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed some interactions between staff and people were kind and caring. However we also observed examples where people's privacy and dignity had not always been respected.

People had been provided with opportunities to express their views about the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was insufficient opportunity for people to take part in meaningful activity to reduce the risk of social isolation.

There was very little evidence to demonstrate care had been planned in a person centred manner.

People and their relatives had opportunities to give their views about the service they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The current registered manager understood what was needed to promote a positive culture which was open and inclusive. However, further time was needed to embed the necessary changes to improve the quality of the service overall. they had not been in post long enough to make the changes required.

Staff were well supported and were clear about their roles and responsibilities.

Quality monitoring systems were in place and action had been taken to address shortfalls in the quality of the service provided to people. However, this inspection identified further areas for improvement and further time was required to make and embed the planned changes.

Homeleigh

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. The 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 19 and 20 May 2016 and was unannounced. The inspection team consisted of an inspector and a specialist advisor in nursing and dementia care.

Before the inspection we examined information we had about this service. This included previous inspection reports and statutory notifications the registered person had sent us. A notification is information about important events which the provider is required to tell us about by law. We used all of this information to help us decide which areas to focus on during the inspection.

We spoke with four people who lived at the service. We also carried out observations of the care and support provided to people over lunch time. We used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who were unable to talk with us. We spoke with the representative of the provider, the registered manager, the deputy manager, a registered nurse, the chef, and two care assistants who were on duty. We also spoke with a health care professional who was visiting the service.
We observed care and support being delivered in the lounge and dining areas. We also spent time during the afternoon observing the activities provided. We also observed medicines being administered at lunchtime.

We reviewed a range of records relating to the management of the home and the delivery of care. They included care plans for four people, medicine administration records (MAR) for 22 people and weight records for 27 people. Management records included the provider's quality assurance records, staff rotas for a period of four weeks, minutes of recent staff meetings and the training records of all the staff employed at Homeleigh.

The service was last inspected on 7 November 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and protected whilst living at Homeleigh, but did have concerns about the consistency of staff available to support them. One person told us, "On the whole, I am treated quite well. Sometimes the staff are quite busy and I have to wait some time before my call bell is answered. There are so many agency staff, I don't remember all their names." Another person told us that at times the staff (who the person said were very kind) could not always get to them quickly enough when they need to get to the toilet. A relative commented, "An enormous amount of qualified staff have left during a short period of time including the manager and the head of care. Another member of staff tells me they are leaving because they are fed up with working with unqualified staff."

We spoke with a visiting health care professional. They informed us they were concerned about the high number of agency staff that had been employed. They told us, "Because of the staffing situation the home has lost the consistency, calmness and ownership of care that it displayed before." They also said, "The care provided, including end of life care, has been very good. Although nurses will make calls to the surgery at appropriate times, I am concerned because the number of requests for visits from the GP or the district nurses has gone up."

We raised these concerns with the registered manager. We were advised that, currently there were 25 people currently accommodated at Homeleigh. We were also advised of the staffing levels provided on the day. Between 8am and 2pm one nurse supported by a team of six care assistants were on duty. From 2pm to 8pm one nurse was supported by a team of five care assistants. At night one nurse and three care assistants were awake and on duty. In addition, a chef and a kitchen assistant were on duty to prepare and cook meals, together with a team of three domestic staff and a laundry assistant who were responsible for keeping the premises clean and for washing people's clothes and bed linen. Our observations indicated that staffing levels provided were sufficient to meet the needs of people accommodated.

We were provided with copies of rotas for all staff for a period of four weeks from 2 May 2016 to 29 May 2016. This confirmed the staffing levels described above. Although sufficient numbers of skilled staff had been deployed, we found that there was a high reliance on agency staff for both nursing and care staff vacancies. Of the nursing and care staff on duty on the day we visited, only two were permanent staff, whilst the others, including the registered nurse, had been supplied from an agency. A similar pattern emerged from information recorded on the rotas for the period identified. The registered manager advised us that, to ensure consistency of care, an agreement had made with the agency to provide the same members of staff from them. We found no evidence that the current staffing situation meant that people's needs had not been met safely but that consistency of staff deployed was an area for improvement.

The provider had drawn up a document to assist the registered manager in determining safe staffing levels. This document advised the registered manager to use each person's Waterlow score as a means to help assess their individual needs. The hours allocated ranged from five hours per person per day, where the score was very high, to two hours per person per day, where the score was low. The document also referred to other sources of guidance including Royal College of Nursing (RCN) guidance on safe nurse staffing levels

published in December 2010. The document also advised the registered manager of other issues that needed to be taken into account. For example, the need for people to be accompanied to appointments, the need for new staff to be supernumerary, cover for staff training and entertainment provided. The registered manager also told us they assessed people's needs daily to help them determine the staffing levels required. For example, due to a recent outbreak of chest infections, staffing levels had been increased by one care assistant for 8am to 8pm each day over the last two weeks.

There were effective staff recruitment and selection processes in place. The registered manager confirmed that applicants were expected to complete and return an application form and to attend an interview. The application included information about their previous employment, education, evidence of appropriate training and their current health. We examined recruitment records of two staff members who had been recruited recently. They confirmed the recruitment process that had been described by the registered manager. They also provided documentary evidence that the necessary checks, including Disclosure and Barring Service (DBS) checks, references, proof of identity, and proof of registration with regard to trained nurses had been undertaken before staff commenced work. DBS checks help employers make safer recruitment decisions and help prevent unsuitable staff from working with people. Staff we spoke with confirmed the checks and documentation they were expected to provide.

The registered manager informed us how they ensured people had been protected from the risk of possible abuse. They advised us that this would be done by providing staff with training. They also told us, "We expect that observations must be carried out by everyone and staff are expected to report anything of concern to me, to social services, and to the Care Quality Commission (CQC)."

Staff we spoke with knew how to keep people safe; they were able to identify signs of possible abuse and knew what to do if they witnessed them. They also informed us they had started work at Homeleigh four weeks ago and they had yet to receive training in this area. Their knowledge stemmed from training they had received previously. Training records indicated not all staff had received training in reporting and identifying abuse, whilst other had not received refresher training for some time. This is dealt with in more detail under the EFFECTIVE domain.

There was a system in place to assess people's needs, to identify risks and protect people from harm. Risk assessments identified where people required help. For example, they identified people who were at risk of pressure sores, falling and malnourishment. Care records provided guidance for staff to follow to ensure identified risks had been reduced. Records we looked at also confirmed the action taken to reduce the risks identified. For example, we saw a repositioning chart, a record of food eaten and of fluids taken for someone was being nursed in bed. However, where pressure relieving mattresses were in use, we could find no evidence to demonstrate they had been routinely checked to ensure the settings of each mattress were appropriate for the needs of the individual. We brought this to the attention of the registered manager as an area requiring further improvements.

There were several gaps in Medication Administration Record (MAR) sheets we examined which meant there was no clear record that these medicines had been administered as prescribed. Several people had been prescribed Warfarin, a medicine used to thin the blood in order to prevent clotting. The dosage to be given is dependent on the result of routine blood tests that needed to be done on specific dates. There was evidence that blood tests had been carried out and the dosage changed accordingly. However, there was no evidence within care plans that potential risk of bruising and bleeding had been identified for those people prescribed medicines to prevent blood clotting. There was no evidence of guidance for staff to follow with regard to minimising any risks to the person when care was delivered. For example, gentle handling when the person needed to be mobilised or using a soft toothbrush for oral hygiene. We brought this to the registered

manager's attention as an area for further improvement. People were prescribed when required (PRN) medicines, mainly for pain management and constipation. However, guidance for nurses to follow with regard to when, why and how such medicines should be administered had not always been drawn up. There was no recorded guidance for staff to follow which provided options for alternative approaches when people who were unable to communicate their needs or expressed distressed behaviours. For example, such behaviours that may be linked specific needs such as pain, hunger, thirst, toilet needs and meaningful occupation. There was no evidence that shortfalls identified in records had meant people had been harmed or put or been put at unnecessary risk. However we recommend the provider review their practices in relation to safe medicines management to ensure people receive their medicines as required and prescribed.

We were advised that only registered nurses were responsible for administering medicines to people. They informed us they were expected to check that the medicines to be administered were in accordance with the prescribing directions recorded on the Medication Administration Records (MAR). They also informed us they would observe that the person had taken their medicine before recording this. If the person did not wish to take their medicine, this would also be recorded. We observed the nurse on duty administer medicines at lunch time. We observed that practices were in line with what we were told and medicines had been administered safely.

Storage arrangements for medicines were secure, maintained at appropriate temperatures and were in accordance with best practice guidelines.

Requires Improvement

Is the service effective?

Our findings

Staff training records confirmed that training provided included safe moving and handling techniques, food hygiene, first aid, infection control, health and safety, and fire safety training. In addition, nursing staff had received training specific to the needs of the people accommodated. This included caring for people living with epilepsy, diabetes and promoting nutrition and hydration in the elderly. They had also received training in palliative and end of life care. However, we noted that not all staff had received refresher training to ensure their knowledge and skills in these areas were up to date. For example, the record indicated that, of the 10 staff who had received training in understanding infection control, only three had received training in the last year. They also indicated not all staff had received up to date training in identifying and reporting abuse. Of the 16 nursing and care staff employed by the provider, only three staff, including the registered manager, had received training in the last 12 months, whilst training provided to seven staff was at least three years old. There was no record of training provided to six staff, including the two who had recently started working at Homeleigh. This meant that staff may not have the necessary skills and knowledge to provide care effectively to meet the needs of people accommodated.

The evidence above indicated this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a new member of staff. Although they had not yet completed their induction training, they had previous care experience and had been given an introduction to the service and its systems. They told us they felt they had received sufficient training and support so far in their role and had worked alongside an experienced member of staff for a week.

The registered manager advised us how they intended to ensure all staff had sufficient skills and knowledge to provide effective care to people. They told us that new staff were provided with induction training. They also said that, once they had settled into their new role, they would be expected to enrol on a course leading to the awarding of the Care Certificate. This is a nationally recognised training programme designed to train staff working in the care sector to develop working practices to agreed minimum standards. We were also informed that three members of staff had commenced this training. Following this staff would also be provided with training specific to the needs of people accommodated. The registered manager was unable to confirm when this would take place.

People told us they enjoyed the food provided. However, one person raised concerns about the large portion sizes and the temperature of the food when it was served to them. We raised this with the registered manager who agreed to speak with the person to resolve their concerns.

People who were risk of dehydration and malnutrition had been identified clearly within the care records and had fluid and food charts in place so that intake and output could be monitored for any changes. The registered manager had implemented a 'focus' on nutrition and hydration across the home at the time of inspection. Fluid and food charts observed were consistently completed although the target fluid requirements were not always set and goals were not reflected consistently within the care plans or

reinforced within the summary care plans used by the care staff. The electronic care records also enabled individual people's weights to be monitored. Where people had lost a significant amount of weight there was evidence this had been quickly addressed, and the trend reversed. Some people, where weight loss had been recorded, were also being supported with palliative and end of life care. The support and interventions required for each had been appropriately recorded and were in line with advice and guidance provided by healthcare professionals.

People told us they had been consulted about their care plans and had given consent to the care provided. Care records confirmed this was the case and included written consent to the use of bedrails. However one person advised us that their care had not been provided in line with their preferences and wishes. They told us they had requested that personal care should be provided by the same gender of staff. They commented, "I prefer the ladies to attend to me. But sometimes I have a man. I have got a bit more used to it, but I think the girls are more gentle." We raised this with the registered manager who expressed surprise that the person's preferences had not been fulfilled and confirmed they would take the necessary steps to address this.

An electronic care planning system was in use supported by care folders with paper records. There were copies of the electronic care plans within each person's care files as only the nurses and management currently have access to the electronic files. Each person had a care folder within or just outside their bedroom with a summary care plan at the front of the folder which detailed the individual's basic care needs and reflected risks and safe system of work for moving and handling. There was a weekly daily care log booklet completed by care staff three times a day. Care records we looked at had been consistently completed.

The registered manager confirmed they were in the process of organising and updating care records as information could not always be found on the electronic system. We were advised that, as from the beginning of May 2016, a 'resident of the day' had been identified. This meant that the identified person's care plans, including risk assessments would be reviewed and discussed with them, or their relatives to ensure the care provided met their needs and wishes. We found evidence that these changes had begun. The registered manager also informed us that, on admission, each person would be asked about their wishes and preferences. For example, when they wanted their breakfast or if they preferred a bath or a shower. We were advised that the care plan for a person who had recently been admitted was in the process of being drawn up. This demonstrated that the person had been consulted with regard the care and support they required.

We checked whether the service was working within the principles of the Mental Capacity Act 2015 MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of
people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to 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 registered manager confirmed that seven people had been assessed as lacking capacity to make decisions for themselves. Of these, DoLS applications on behalf of four people had been sent to the local authority, of which one had been granted. Care records included appropriate documentation which gave the reason for the restriction and the length of time they would be place before a review was required. There

was also evidence that, where necessary best interest decisions had been made on behalf of those considered not able to make specific decisions for themselves. Staff we spoke with confirmed they understood the principles of the MCA, but were unable to describe how they related to the needs of individuals. This was because they had commenced work in the past four weeks and were still getting to know individual people and their needs.

People were supported to maintain good health by having regular access to health care services. The nursing staff would contact the GP on their behalf if they needed an appointment when they were unwell. Arrangements would be made for GPs to visit the person at Homeleigh, or, if the person wished, appointments would be made to visit the GP at their surgery. The manager confirmed arrangements would be made to accompany the person if this was required. We saw that visits made by the GP to people had been recorded together with any treatment prescribed.

Requires Improvement

Is the service caring?

Our findings

We found no evidence within the care plans we looked at of people being actively involved in their care planning, review and evaluation of their care. However, people we spoke with confirmed they had been consulted about how their wishes and preferences with regard to how care was to be delivered. The registered manager confirmed they had begun to review everyone's care plans under the 'resident of the day' strategy. They also advised us that people and, where appropriate, their relatives would be involved in discussions about their care. People's views and opinions would also be recorded within guidance which all staff would be expected to follow to ensure care delivery met their expectations.

We sat in the dining room to observe the lunch-time experience. The dining area was clean and bright and had been recently decorated. There were nine people sitting in the dining room to eat their main meal of the day. There were two agency staff present to provide people with assistance. We observed three people being served and helped with their meal. The staff were kind and pleasant, but were largely focussed on tasks rather than providing person centred care. Each person required some assistance to eat, either by prompting or needing staff assistance to eat. Although they had been allocated to help one person, one member of staff kept getting up and doing something in another part of the dining room. This meant that any interaction between the staff member and the person kept being disrupted. When they sat down again they did not warn the person before they presented another mouthful of food to them. At one point the person appeared to completely lose interest in the food they were eating. In contrast, we observed another member of staff who did sit with the person they were helping until they had finished their meal and ensured the tempo eating was set by the person. However, we observed very little interactions aside from the task of helping people to eat. This meant that there were missed opportunities to ensure meal times were interactive, person-centred and encouraged people to eat and drink in sufficient quantities.

Care staff we observed did not always knock before entering people's rooms. Some domestic staff were observed to enter the rooms of people who were sleeping and started to clean, without permission. This meant that people's dignity and privacy may not have been respected. We shared our observations with the registered manager. We recommend the provider consider the mixed experiences of the caring approach of staff we observed to ensure all people living at Homeleigh receive compassionate and dignified care and treatment.

The provider's website set out its values and approaches to the provision of care to people living at Homeleigh. It stated:

'Based on our core value of dignity through respect, we understand how important it is to remember that a person requiring care is still a unique individual. We therefore endeavour to ensure that we do everything we can to help the service users retain their sense of identity and feelings of self-worth; to be treated with respect and valued for who they are.

Our approach to care is to recognise that service users will have their own experiences of life, their own needs and feelings, likes and dislikes. In our care planning we take account of service users' abilities,

interests and preferences and aim to respond flexibly and sensitively. We focus on what the service user can do rather than what they cannot do. Our primary goal is to rebuild the service user's self-esteem, self-confidence and the restoration of personal dignity leading to an improved quality of life.'

The registered manager advised us how staff were expected to develop positive caring relationships with people. They would be expected to talk to people in order to get to know them individually. They would also be expected to refer to care records to ensure they understood people's individual needs and wishes. The registered manager also referred to the Care Certificate as an opportunity for all staff to develop the skills and knowledge they would need to help them develop appropriate relationships. They also identified that supervisions for all staff would provide them with a place to discuss, reflect on and improve their skills.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they did not always feel the care provided was responsive to their needs. One person told us they felt isolated. They told us, "There are times when I feel trapped and very alone". This was partly due to having experienced sudden sight loss before admission. There was insufficient detail in their care plan relating to the impact of their sight loss and support they required to accommodate the complications associated with their current condition. It was clear the loss of sight had almost certainly increased the person's anxiety and need for an increase in support and reassurance but this was not reflected in the plan of care.

There was insufficient meaningful occupation for the people living at Homeleigh, particularly in relation to people who lived with dementia and people who were cared for in bed. This meant people's social needs may not have been met and that they were at risk of isolation. A member of staff had recently been appointed to organise and provide activities. However they had very limited time in the afternoon to provide activities. This amounted to an hour each weekday between 2pm and 3pm. We spoke to them and they expressed a great deal of enthusiasm for their new role. However, they have had no formal training or induction to the role. We were advised that some activities had been provided from outside agencies. This included gentle exercise sessions twice a month, reminiscence sessions twice a month and visiting musicians once a month.

An electronic care planning system was in use supported by care folders with paper records. There were copies of the electronic care plans within each person's care files as only the nurses and management currently had access to the electronic files. Each person had a care folder within or just outside their bedroom with a summary care plan at the front of the folder which detailed the individual's basic care needs and reflected risks and safe system of work for moving and handling. There was a weekly daily care log booklet completed by care staff three times a day. Care records we looked at had been consistently completed. Some people's care records had some information about their background and their life story. However, this had not been used in care plans to develop truly personalised care that reflected the identity of person and promoted activities that were meaningful to each individual. The physical needs of people had been met in a task focused way with little evidence of supporting people's emotional, psychological and spiritual need. Therefore the way care was planned and delivered to people was not consistently person-centred.

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

The registered manager had been in post a relatively short time and demonstrated an understanding of the need to further personalise and develop the support provided. They told us they were working on recruiting and developing a team who would be able to provide this level of care.

The registered manager confirmed they were in the process of organising and updating care records as information could not always be found on the electronic system. We were advised that, as from the

beginning of May 2016, a 'resident of the day' had been introduced. This meant that the identified person's care plans, including risk assessments would be reviewed and discussed with them, or their relatives to ensure the care provided met their needs and wishes. We found evidence that these changes had begun. The registered manager also informed us that, on admission, each person would be asked about their wishes and preferences. For example, they would be asked when they wanted their breakfast or if they preferred a bath or a shower. We were advised that the care plan for a person who had recently been admitted was in the process of being drawn up. This demonstrated that the person had been consulted with regard the care and support they required.

The registered manager advised us they had held one meeting with people and the families since they had been appointed. This had been used to advise people and to discuss with them the plans to refurbish and redecorate the reception area and dining room. We saw evidence of the completed work during our visit. These areas appeared fresh, clean and had been presented in a welcoming manner. We were also advised that the registered manager intended to meet with people and their families every three months to provide them with an opportunity to discuss any issues and to provide suggestions or ideas to improve the service provided.

The provider had recently sent out satisfaction questionnaires to people and relatives in order to obtain information about the views and opinions of the services proved. We were given copies of an analysis of the responses received which had been dated March 2016. This indicated 14 people out of 23 had returned questionnaires, whilst two relatives out of 23 had returned theirs. The report we looked at identified a range of questions people had been asked to which people could answer yes, no, sometimes, or never. The majority of responses were very positive. For example, 13 people confirmed that Homeleigh had met their expectations and 13 people confirmed they had been consulted about their care. However, it was not clear from the information provided how the provider had responded to negative comments. For example, one person had said they were not aware of the provider's complaints procedure and one person said the staff were not caring and friendly. These concerns had not been addressed to ensure improvements were made and the person's experiences improved.

People told us that they would know who to speak with if they had concerns or if they wished to make a complaint. One person said, "I would tell (the nurse on duty) but as they as so busy they probably forget what I have said. I have met the manager. She is very nice; she is trying to get a new bed for me at the moment." The provider's complaint procedure was on display in the reception area just outside the office. The registered manager advised that a copy was also in a welcome folder which included useful information a person might need to know, which was issued to them on admission. We were shown a record of complaints received which demonstrated that they had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

The current registered manager was appointed in December 2015. At the same time, one senior and long-standing members of staff chose to retire . In addition, two staff have been absent due to sickness for an extended period of time. Therefore there has been a significant change in the staffing and leadership of the home over the past six months. The numbers of staff on duty have been maintained by employing staff on a temporary basis from external staffing agencies. The registered manager has sought to reduce the potential for loss of continuity of care by securing agreements from agencies to supply the same staff to Homeleigh on a consistent basis. We have elaborated on our assessment of staffing levels deployed in the SAFE domain of this report.

We have received a number of complaints and concerns regarding the current number of staff vacancies which has meant a large number of agency staff have been employed. The registered manager demonstrated they were aware of these concerns and had begun to address them. They have also told us they will need to concentrate on the recruitment and appointment to staff vacancies before they would able to introduce and embed the changes and improvements they have planned.

A representative of the provider gave us a document they had drawn up which identified their plans for recruitment including timescales. They also confirmed that, until they were able to recruit more staff, they had voluntarily agreed they would not accept new admissions to Homeleigh. This was to ensure the safety and consistency of care provided to people who already lived there. Although the registered manager was transparent, open and eager to make positive improvements, further time was required to ensure changes were made and embedded to improve people's experiences. The registered manager said, "I am aware that currently the home is being run on a task based approach. We need to move away from this to a person centred culture. We need to be more open and accountable. We need to look into any feedback we receive and learn from it. The major issue at the moment is to move the staffing situation forward. We need to appoint more of our own staff. Then we need to make staff feel an ownership and pride in what we are doing. We need to spend more time with people and find out about their lives and what their needs are. This will help us to treat them as individuals and to make sure they are comfortable and safe."

We have been informed that, since this inspection, a registered nurse and two care assistants had been recruited. This meant that the only permanent vacancies that remained were for a full time registered nurse to work during the day and a care assistant to work one night a week. Agency staff were still employed but, apart from these vacancies, were covering planned annual leave or sick leave.

Staff confirmed they felt well supported in their work. One member of staff, who was appointed four weeks ago said, "I was in the office with (the registered manager) last week to talk about how I am settling in. I think the care here is quite good. It is a nice place to work." We also were shown evidence that the registered manager had begun a programme of ensuring all members of staff have received planned supervision at regular intervals by either herself, or a more senior member of staff. This provided staff with an opportunity to sit down to discuss their work, the care practices, the aims of the organisation and their training needs.

The registered manager also provided us with documentary evidence that demonstrated how the service had been monitored. They included routine health and safety checks and maintenance of the environment, the management of medicines and infection control. There were also regular audits of complaints, accidents and incidents in order to determine if there were patterns or factors that could be learnt from. In addition care records and staff recruitment records had been routinely checked to ensure they had been kept accurately. Each audit included an action plan which identified when the work needed to be done by, and by whom to ensure compliance.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured persons employed by the service provider in the provision of a regulated activity had received such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)