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Homelands

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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection was unannounced and took place on 5 and 6 November.

Homelands is registered to provide care and support for up to 20 adults and older people living with mental illness or dementia. At the time of this inspection, there were 14 people living at the home, five of whom were older persons living with dementia and nine were adults living with Korsakoff's syndrome or mental illness. Korsakoff's syndrome is a brain disorder commonly associated with misuse of alcohol.

A registered manager was not 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. This post has been vacant since 10 May 2014. Since then there has been three managers employed. The most recent manager was appointed approximately five weeks before our visit; they were present at this inspection. The provider has since notified us that this manager has left and another manager has been appointed. This has had an impact on the consistency and leadership of the service.

Summary of findings

People said they felt safe at Homelands. We observed staff delivered care and support to people safely, with compassion and understanding.

Staff were able to identify signs of possible abuse and knew what to do if they witnessed them. However, not all staff had received up to date training in this area.

We observed that staffing levels ensured people's immediate needs could be met safely. However, the feedback we had from people, staff and the manager was that the current staffing levels did not always ensure people had social stimulation and access to activities of interest. In addition there was no system to allow the provider or manager to assess the staffing levels required based on people's needs.

Medicines were been stored, administered and managed safely.

People said the food was good and there was a choice. Where necessary, people were given appropriate support to eat.

Care records indicated risk assessments had been carried out but the information included in them was vague. Identified risks had not been transferred to care plans and records of care and treatment to be provided were not up to date or complete. Guidance for staff on how to mitigate risk was not clear or updated. This meant risks to people may not be effectively managed to reduce the likelihood of occurrence or recurrence.

Information held in care plans had not been kept updated to ensure it reflected people's current needs. The details included in care plans to guide staff were not sufficiently clear or kept updated to ensure staff knew how to support people with their current needs. Although people said they were consulted in decisions about their care, there was not documentation of this to confirm how people or their representatives were involved.

A limited programme of activities had been provided. However, it was not clear how activities were provided for the needs of people who needed more staff support. This meant they were at risk of isolation and withdrawal.

Staff had not routinely received induction and supervision to ensure they had the necessary skills and knowledge required to carry out their work. Staff training records indicated training had not been kept up to date and some staff had received no training at all in some essential areas, such as understanding dementia, safeguarding and managing challenging behaviour such as aggression.

Staff had not received appropriate training to ensure they understood their role in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that any restrictions to their freedom or liberty has been authorised by the local authority as being required to protect the person from harm. We did see examples of how best interest decisions had been made appropriately on behalf of people who did not have the capacity to consent to decisions about their care. However we found that appropriate mental capacity assessments had not been completed to determine people's decision-making capacity before making a DoLS application for potential restriction of people's liberty.

People and the staff had been asked for their views of the quality of the service. However, there was no evidence which demonstrated how comments and suggestions received had been considered and, where appropriate, implemented to improve the service.

A quality assurance system was not in place to monitor how the service had been provided and to identify and respond to shortfalls.

We have identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told this provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Risks to people had not been managed safely. Care plans did not have sufficient information for staff to follow to ensure people's needs had been met and identified risks had been reduced where possible.

Staff had not received sufficient training and guidance in safeguarding adults. However staff understood understood how to identify and report abuse.

Although there were sufficient staff to meet people's immediate needs, there were concerns that the staffing levels did not enable people to partake in activities and social stimulation. The provider did not have a clear system for assessing the staffing levels required based on people's needs..

Medicines were administered and managed safely.

Requires improvement 

Is the service effective?

The service was not always effective.

Staff had not received sufficient induction, training and supervision to ensure they able to carry out their work effectively

People were supported to have sufficient to eat and drink.

When people did not have the capacity to consent, suitable arrangements had been made to ensure decisions were made in their best interests.

Mental capacity assessments had not been carried out prior to making Deprivation of Liberty Safeguard (DoLS) applications being made to determine why this safeguard was required.

People had access to healthcare services and had received ongoing healthcare support.

Requires improvement 

Is the service caring?

The service was caring.

People were supported by kind and friendly staff who responded appropriately to their needs.

People said they were involved in making decisions and choices about their care and support.

People's privacy and dignity was promoted and respected.

Good 

Is the service responsive?

The service was not responsive.

Requires improvement 

Summary of findings

Care plans had not been reviewed in a timely manner to ensure care delivery was responsive to people's changing needs and had been provided in accordance with their wishes and preferences.

There were insufficient activities available for people living with dementia to keep them engaged and to avoid isolation.

People felt able to raise concerns they had about the service with the manager. There was a clear complaints procedure in place. However the manager was unable to locate the record of historical complaints which meant we were unable to see how this procedure was applied.

Is the service well-led?

Inadequate

The service was not well led.

The service had been without a registered manager for 18 months. During this period the provider has appointed several managers. This has had an impact on the consistency and leadership of the service.

Quality monitoring systems were not in place and patterns of accidents and incidents had not been were analysed. Therefore the provider had no system to effectively assess the quality and safety of the service and to take action where shortfalls were identified.

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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 5 and 6 November 2015 and was unannounced. The inspection team consisted of two inspectors.

We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law. We used this information to decide which areas to focus on during our inspection.

Some people who used the service were unable to verbally share their experiences of life at Homelands because of their complex needs. We therefore spent time observing the care and support they received over lunch time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with five people who lived at Homelands. We also spoke with three care staff, the cook and the manager.

We also looked at the care plans, risk assessments and other associated records for three people. We reviewed other records, including the provider's internal checks and audits, staff training and induction records, staff rotas, medicine records and accidents, incidents and complaints records. Records for two staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was previously inspected on 13 February 2014 where no concerns were identified.

Requires improvement

Is the service safe?

Our findings

There was a system in place to assess people's needs, to identify risks and protect people from harm. We looked at the assessment records for one person who had recently been admitted. This person lived with dementia. The document provided information about their needs in relation to eating and drinking, communication, hearing, speech, understanding, mobility, risk of falls, awareness and orientation, mood, social care and personal safety. However the information which had been recorded in risk assessments was basic and very general. For example, it recorded, 'History of occasional falls.' There was no information about how and when this person may be at risk. In addition, information about how to meet this person's individual needs was not sufficient to ensure staff knew what to do to reduce the risk of this person falling. For example, information recorded stated that, '(Person's name) is at moderate risk of falls due to being unsteady on their feet.' Records stated, '(Person's name) uses frame when mobilising. Requires one carer to assist.' There was no clear guidance for staff to follow with regard to how the same person should be assisted when they used their walking frame to ensure identified risks had been reduced.

We looked at risk assessments of a second person who had been diagnosed as living with Korsakoff's syndrome. There was no information about this and how it affected the person. The assessment advised staff this person was prone to aggressive behaviour. However, there was no information for staff to follow with regard to what might trigger this behaviour and what could be done to distract the person or de-escalate this person's behaviour. We have been advised that the service can no longer meet this person's needs safely and they have had their placement terminated. However, we were advised that there were a further eight people at Homelands who also had the same condition and associated risks. Whilst we were not made aware if anyone else with a tendency to aggressive behaviour, risk assessments and care records were not sufficiently robust to ensure, where possible, any potential risks had been reduced.

Each of the above examples meant that risks to individuals and the service may not have been adequately managed to ensure care and treatment was provided in a safe way. This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home and that they were safely cared for. For example, one person said, "Yes, I feel safe here."

We observed people were safely supported by staff when people were assisted to move. This included staff providing guidance and support to people when they got up from their chair. We noted one exception to this where the staff member assisted someone to stand by guiding and encouraging them to stand and move with the aid of a frame. The staff member noticed the person's trousers were loose but had not ensured they were sufficiently pulled up which could have posed a tripping hazard to the person. We had to request the staff member to assist the person as the person did not appear safe.

Of the three staff we spoke to only one could confirm they had received training in identifying and reporting possible instances of abuse. Training records confirmed that four of the nine members of staff employed at Homelands, had received training in this area. The manager was aware not all staff had received training and informed us they intended to address this by introducing a training package for all staff. Despite this, staff demonstrated they were aware of safeguarding procedures and knew what to do if they considered someone was being abused. The staff knew they could report suspected abuse to the local authority safeguarding team.

People told us they considered there were enough staff to look after them properly. We observed two staff were available to support people and there was a third staff member who was completing their induction, who was considered supernumerary to the rota Staff were provided in sufficient numbers to assist people with their meals at lunch. There were periods when staff were not present in the lounge which was where most of the people sat during the day. Staff told us they considered a third staff member on duty would mean people had greater access to staff and one staff member said there was a lack of activities due to the current staffing levels.

We were informed that between 7am and 7pm each day, there were two care assistants on duty. Between 7pm and 7am each night two care staff were on duty: one on 'waking' duty and the other on 'sleep in' duty. We were provided with copies of staff rotas covering three weeks

Requires improvement

Is the service safe?

from 24 October 2015 to 13 November 2015. They confirmed these staffing levels had been maintained throughout this period. The manager was unable to confirm how staffing levels had been calculated.

We noted that the majority of night shifts had been covered by agency staff. The manager assured us that the same staff came from the agency to cover shifts to ensure continuity of care. The manager also confirmed they were in the process of recruiting new staff to current vacancies.

We recommend that the provider review their systems for calculating staffing levels required based on need to ensure that the current staffing levels were sufficient to meet people's needs.

There were effective staff recruitment and selection processes in place. We were informed that applicants were expected to complete and return an application form and to attend an interview. In addition, appropriate checks and references were sought to ensure any potential candidate was fit to work with people at risk. We looked at the recruitment records of two staff which demonstrated the recruitment process was robust and promoted safe recruitment decisions. Staff said their recruitment involved an interview to assess their suitability for the job as well as references and other background checks being obtained.

There was a written medicines policy for the handling, storage, administration and disposal of medicines as well as a homely remedies policy. Medicines and medicines administration records (MAR) were securely stored when not in use. The temperature of the fridge used for storing some medicines was monitored so the medicines were kept at the advised temperature.

The service used a monitored dosage system to administer medicines. Staff recorded their signature each time they supported someone to take their medicines. There was a photograph of each person with their MAR chart so staff were aware of the right person to administer medicines to. We checked a sample of the blister packs of medicines which showed medicines were administered as prescribed. Staff monitored the blood sugar levels of people who had diabetes. These were recorded and staff knew the range of acceptable levels and what to do if the readings were outside of this. Staff told us they were trained in the service's medicines procedures which involved direct instruction from another staff member plus an observation of them to assess their competency in this. We saw people had medicines to be taken on an 'as required' basis. Staff told us they knew the circumstances of when this was needed.

Requires improvement

Is the service effective?

Our findings

On the day of the inspection we saw a staff member was completing their induction and was supernumerary to the two care staff so they could observe and learn the job. Another staff member who had started work recently told us they did not receive an induction other than to work one day as a supernumerary staff member after which they worked as a member of the staff team. The staff member did not consider this equipped them fully for this role.

Staff said they received training in subjects such as first aid, moving and handling, and fire safety as well as undertaking training which resulted in the awarding of the National Vocational Qualification (NVQ) in Health and Social Care. One staff member said the training was "good" whereas another staff member pointed to omissions in subjects such as safeguarding, understanding the needs of people living with dementia and the Mental Capacity Act 2005. Training records we looked at confirmed not all staff had received appropriate training, and refresher training at regular intervals, to ensure they had the necessary knowledge and skills they required to carry out the work expected of them. For example, of the eight staff who appeared on the rota to provide care, only three staff had received training in fire safety, four in identifying and reporting abuse, and three in first aid. In addition, four staff had received training in understanding dementia, two in managing challenging behaviour. There was no evidence that staf had received training in understanding the needs of people who lived with Korsakoff's syndrome, of which several people using the service had a diagnosis. Therefore staff were were not fully informed or knowledgeable about how to provide care and treatment effectively and safely to people.

We asked staff if they received supervision. Whilst they said they felt supported in their work and could ask for advice they said one to one supervision was infrequent. One staff member said they received this every six months but then said they didn't know how often and a recently appointed staff member said they had not received any supervision or appraisal since starting work.

The above evidence meant that all staff had not received appropriate training, support and supervision to enable them to carry out their duties. This is in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, people told us they considered the staff were skilled in their work. For example, one person said, "The care and staff are excellent. The staff are skilled and I'm getting better."

The manager informed us, where people lacked capacity to make decisions they and the care staff would be guided by the principles of the MCA to ensure any decisions were made in their best interests. We saw evidence of this when one person's physical condition had deteriorated recently. The GP was called and considered that this person now required end of life care. The family were notified of this decision and discussions took place with regard to how best the interests of the person could be served.

We were also informed that four people were considered not to have capacity to make decisions, but no formal capacity assessments had been carried out. Yet, despite this, the provider had applied for Deprivation of Liberty Safeguards (DoLS) authorisations for two people. These safeguards protect the rights of people by ensuring that any restrictions to their freedom or liberty has been authorised by the local authority as being required to protect the person from harm. Following discussion, the manager demonstrated they were aware of the principles which governed the lawful use of DoLS. However, they were unable to explain why DoLS applications had been made before capacity assessments had been completed to determine the person's capacity to consent to any restrictions. This meant that the correct process had not been followed to ensure, where people's liberty had been deprived, this had been done lawfully. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At lunchtime we observed people were supported to eat and drink. There was a choice of food and staff told us people were asked in advance by the cook what they would like to eat for the midday meal. Staff supported and encouraged people to eat and asked people if they wanted something else if they did not eat. People commented on how much they liked the lunch..

The cook told us how cream and full fat milk were used to provide calorific value to the rice pudding. Pureed meals were provided to those who needed this and we saw how individual items were pureed separately so people experience the different tastes as opposed to pureeing it

Requires improvement

Is the service effective?

together. Staff were observed to assist those who needed support with eating. People had access to drinks throughout the day and we observed staff responded promptly if a person asked for a snack such as biscuits.

People were supported to maintain good health by having regular access to health care services. The 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 Homelands, 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. The manager also confirmed, where necessary, access to specialist services for people living with dementia would be arranged via the GP. We saw that visits made by the GP to people had been recorded together with any treatment prescribed.

Good

Is the service caring?

Our findings

People told us the staff were kind and friendly. For example, one person said, “The staff treat you with a humanity which makes me feel that they care.” Another person described the staff as friendly and as lovely people. People said staff took time to talk to them although one person said staff were sometimes too busy to do this.

People also said they were able to make choices in how they spent their time and could maintain their independence. For example, one person said, “They look after you well. They don’t keep bothering me. They respect my privacy and freedom.” People told us they had been consulted in decisions about their care and some said they were enabled to participate in activities of their choosing.

Staff were observed to have positive and caring relationships with people. This included staff and people chatting and joking together and it was clear staff and people knew each other well. People said they had a good rapport with the staff and said they had fun with the staff.

We observed staff were kind and attentive to people. This included making conversation with people as well as checking people when people showed signs of discomfort. Staff spoke to people respectfully and knew people’s preferences. They interacted by speaking to people by making eye contact, crouching down to meet people at eye-level and using appropriate gestures and touch to reassure or to respond to people.

Staff demonstrated values of compassion and concern for people’s well-being. A staff member said the staff team were “all heart,” treated people well and in a person centred way to acknowledge people’s individuality. Staff also said they provided care in the way they would wish themselves or one of their family to be treated.

People said their privacy was respected and we observed staff knocked on people’s bedroom doors before entering. Staff informed us they would draw curtains and shut doors before providing personal care.

Requires improvement

Is the service responsive?

Our findings

Care records we looked at demonstrated people's needs had been assessed on admission. However, they also indicated care plans had not been reviewed since June 2015 to reflect people's changing needs. Whilst people said they were consulted about their care, there was no evidence to show this when people's care reviews took place. In addition, care plans had not been reviewed after significant events had occurred to ensure information reflected the current care needs of individuals. For example, one person's care plan had not been updated to reflect the outcome of a recent best interest meeting to discuss changes to the care they required. This person had deteriorated physically and now needed to be cared for in bed. It was recorded that the GP had diagnosed the person as requiring end of life care. The guidance to staff only advised, 'Carers to ensure (person's name) is kept warm, comfortable and dry, and to provide lots of TLC (tender loving care).' This was not in sufficient detail for staff to understand how to support this person and their wishes for end of life care. This meant the staff did not have up to date and specific information to ensure the care provided was responsive to people's changing needs and reflected their personal preferences and wishes.

Staff said the range of activities for people needed to be improved and one person told us there was a lack of activities. During our visit we did not observe any activities taking place or see any notices about forthcoming activities. Whilst some people were able to go out safely on their own there were no outings planned for those who needed staff support to attend any community event or to go to the shops. This meant that people who lived with dementia may be at risk of isolation and withdrawal. We discussed our findings with the manager who confirmed activities had been limited due to staff vacancies. This did not ensure that people's needs in relation to social or occupational stimulation were being met.

The provider had not ensured that people's care and treatment had been assessed, planned and carried out to meet their individual needs and changing circumstances. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, some people told us the care and support they received met their needs. One person said how they attended college courses and showed us certificates of attainment in subjects. One person highlighted how they felt their condition had improved since being admitted to the home. We observed staff responding immediately to people's requests for assistance with personal care.

People we spoke with confirmed they knew who to speak to if they had concerns. They also told us they knew what to do if they wished to make a complaint. They were confident that the manager would listen to them and would take seriously any concerns they had. The provider's written compliant procedure was on public display. The manager advised us that, since their appointment they had not received any complaints. However, they were unable to locate the complaints record which meant we were unable to determine if historical complaints had been appropriately investigated and resolved.

We recommend the provider consider how complaints are recorded and stored to ensure these records are accessible for the manager and staff to evidence how complaints have been dealt with.

Inadequate

Is the service well-led?

Our findings

Homelands has been without a registered manager since May 2014. Since this time the provider has advised us of the appointment of a succession of managers, but none have registered with us as required. We met with the current manager at this inspection who advised us they had been employed at the service since 14 September 2015. However, the provider has since advised us that this manager has left and that they have appointed someone to be the temporary manager whilst they recruit to the position. This has meant that, over the last 18 months, there has been a lack of consistency in the management and leadership of the service. This inspection has identified a number of breaches to regulations where significant improvement is required, some of which may be due to the lack of consistent leadership.

The manager was unable provided us with documentary evidence that demonstrated how the quality of the service had been monitored. There were records of staff meetings and meetings with people accommodated; the last of which had taken place in April 2015 and February 2015 respectively. However, there was no evidence that people and staff were encouraged to make suggestions or share any ideas had to make improvements to the service. The manager stated they had a staff meeting in October 2015 to introduce themselves and to discuss how they intended to carry out their responsibilities. A satisfaction survey had been conducted earlier in 2015 and one person confirmed they were asked to give their views on the service by completing a questionnaire. Howeverthere was no evidence of analysis of the information gathered or evidence of action taken to make improvements to the service.

The only evidence of routine audits which had been carried out were audits of medicines, which had been completed on a monthly basis. This was last conducted in September 2105; the manager was unable to confirm if or how this would be continued. We found no evidence of routine checks of the environment, safety checks and maintenance checks. Therefore the provider could not assure themselves that these areas were safe and of good quality.

Audits of falls, accidents, incidents and safeguarding alerts, particularly those which related to aggression between residents which had occurred recently, had not been completed. This meant that the provider had not sought to learn from them to determine if there were any patterns which might help to reduce further recurrence. There was no evidence of a system or process being operated to assess monitor and improve the quality and safety of the service. This is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person said the new manager was “the best.” Another person said the new manager had made a difference to the service due to being more available than previous managers. However we were notified after the inspection that this manager had left. Staff have told us they, generally feel well supported, but have identified where they have there have been gaps in their training, supervision and appraisals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person had not established and operated effectively a system in order to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2) (a). The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (b). The registered person had not maintained securely an accurate, complete and contemporaneous record in respect of each service, including a record of the care and treatment provided to the service user. Regulation 17 (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered person had not ensured that persons employed by the service provider had received such appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not acted in accordance with the 2005 Act where the service user is unable to give consent. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered person had not ensured that care and treatment provided to 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person had not ensured that care and treatment was provided in a safe way. This was because risks to the health and safety of service users had not been appropriately assessed or mitigated. Regulation 12 (1)(2)(a)(b)