Imperial Healthcare (UK) Ltd

Homelea Residential Care Home

Inspection report

15-17 Lewes Road
Eastbourne
East Sussex
BN21 2BY

Tel: 01323722046

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13 September 2017

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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?	**Inadequate**

Summary of findings

Overall summary

Homelea is a residential home in Eastbourne, providing care for people with dementia. Homelea provides long term care and periods of respite. People's care needs varied, some had complex dementia care needs and required full support with all activities of daily living. Other people's needs were less complex and required care and support associated with mild dementia and memory loss. Some people were able to walk unaided or with the use of walking frames, others required full assistance with their mobility. The service is registered to provide care for up to 27 people. At the time of the inspection there were 23 people living at the service including two people staying at Homelea for a period of respite care.

Homelea Residential Care Home was taken over by a new provider in August 2016. We carried out an inspection in January 2017. Were we identified three breech of regulation and we told the provider improvements were needed. The service was rated as requires improvement. This inspection which took place on 12 and 13 September and was unannounced. The inspection was carried out by two inspectors.

At the time of the inspection the registered manager had been absent for a period of sickness and this was due to continue. Since the inspection we have been notified that the registered manager has now left the organisation. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

A deputy manager had been employed and had started the day the registered manager had gone off sick, so had received a minimal handover. Since the inspection we have been informed by the registered provider that the deputy manager has now left the organisation.

We found there was a lack of consistent and strong leadership or provider oversight. Quality assurance systems had not identified issues found during the inspection. Governance systems were not robust.

Accidents/ incidents and falls were not being responded to appropriately or reported to the local authority in accordance with safeguarding protocols. The registered provider and deputy manager did not have an understanding of the expectations in relation to safeguarding people. This included reporting accidents, incidents and falls to other external professionals. People's safety had not been monitored and responded to appropriately.

People did not receive person centred care. Documentation had not been updated or maintained to ensure it was accurate, up to date and contemporaneous. Documentation did not support care that was individualised or person centred.

There had been a high number of unwitnessed falls and incidents. Staffing levels had not been reviewed in response to this. The provider had not ensured that staff had the appropriate, skills, knowledge or

experience to meet people's needs. Individual and environmental risk assessments were not in place when risks to people's safety had been identified. Changes to peoples care needs had not been updated in care plans.

Information regarding Deprivation of Liberty Safeguard (DoLS), capacity and who was legally entitled to be involved in decisions had not been completed in care files. There was no information to show how decisions had been made regarding peoples care needs or who was legally entitled to be involved in decisions. Decisions regarding people's dignity and choices were not always supported.

Activities were provided, however these were limited to set times with minimal access to activities or items to keep people occupied at other times.

Although work had taken place to ensure medicine procedures were in place, further improvement was needed to ensure medicines were consistently safe.

There was on-going improvement to the environment, maintenance and equipment checks were being completed although not all work was consistently documented. Staff interacted nicely with people and responded when people became upset or anxious. Staff were trying to support people with the information currently provided. People were offered a choice of meals, snacks and drinks throughout the day. Records were securely stored, and a complaints policy was in place.

We have been in contact with the local authority and quality monitoring team after the inspection regarding the concerns that we identified.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. And Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this 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

Homelea Residential Care Home was not safe.

Accidents/ incidents and falls were not responded to appropriately or reported to the local authority in accordance with safeguarding protocols.

There had been a high number of unwitnessed falls and incidents; it was unclear if staffing levels had been reviewed in response to this.

Individual and environmental risk assessments were not in place when risks to people's safety had been identified. Changes to people's care needs had not been updated in care plans.

Although work had taken place to ensure medicine procedures were safe, further improvement was still needed.

There was on-going improvement to the environment, maintenance and equipment checks were completed.

Is the service effective?

Requires Improvement

Homelea Residential Care Home was not always effective.

There was no information to show how decisions had been made regarding people's care needs or who was legally entitled to be involved in decisions.

Information regarding Deprivation of Liberty Safeguard (DoLS), capacity and who was legally entitled to be involved in decisions had not been completed in care files.

The provider had not ensured staff had the appropriate, skills, knowledge or experience to meet people's needs.

People were offered a choice of meals, snacks and drinks throughout the day.

Is the service caring?

Requires Improvement

The service was not always caring.

Decisions regarding people's dignity and choices were not always supported.

Staff interacted nicely with people and responded when people became upset or anxious.

Records were securely stored.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive person centred care. Documentation was not in place or updated when changes had occurred.

Documentation did not support care that was individualised or person centred.

Activities were provided, however these were limited to set times with minimal access to activities or items at other times.

A complaints policy was in place.

Is the service well-led?

Inadequate

The service was not well led

There was a lack of consistent and strong leadership or provider oversight.

The registered manager was currently away from the service for a planned period of absence and the deputy manager had been in day to day charge supported by the provider.

Quality assurance systems had not identified issues found during the inspection. Systems used were not robust.

Records relating to the care and treatment of each person were not accurate, complete or updated without delay when changes occurred.

Homelea Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.'

Homelea Residential Care Home was taken over by a new provider in August 2016. We carried out an inspection in January 2017. Were we identified three breech of regulation and we told the provider improvements were needed. The service was rated as requires improvement.

This inspection which took place on 12 and 13 September 2017and was unannounced. The inspection team consisted of two inspectors. We carried out this inspection as CQC had received concerns relating to safe care and treatment. Further information had been received from the local authority regarding these concerns. The inspection was bought forward to allow us to check if the provider was meeting regulations.

Before our inspection we reviewed the information we held about the home. We looked at information and notifications which had been submitted by the home. A notification is information about important events which the provider is required by law to tell us about. We also reviewed safeguarding information that had been shared with us by the local authority and information from the quality monitoring team.

At the time of the inspection there were 23 people living at Homelea. Not everyone was able to tell us about their experiences living at Homelea due to their dementia. We carried out observations over a designated period of time to gain feedback about people's first hand experiences, staff interactions and how people spent their time. We spoke with two visitors and relatives, and four people who lived at Homelea to get their feedback about the home and what it was like to live there. We spoke with nine staff, including the provider, deputy manager, a manager from another service owned by the provider, kitchen, and domestic staff, carers and senior carers working at Homelea during the inspection. We also gained feedback from health

professionals who visited the service and spoke to the local authority and quality monitoring teams.

We looked at two care files in full and a further eleven care files to follow up on specific health conditions and associated care needs, including risk assessments. This included both current paper care folders and newly implemented computerised records. All Medicine Administration Records (MAR) charts were checked and medicine storage and administration was reviewed. We read daily records, handover information, charts and other information completed by staff. We reviewed three staff files and other records relating to the management of the home, such as complaints and accident / incident recording, quality assurance and audit documentation.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2017 the provider was requires improvement in safe and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because it was not clear how people's safety was maintained as risk assessments were not in place for all identified risks, accidents and incident processes were not being followed consistently. Medicine procedures needed to be improved, people were left for periods unattended in the lounge and staff did not follow infection control guidelines.

The provider sent us an action plan stating how they would meet the requirements of the regulations by May 2017. At this inspection improvements had been made in relation to infection control, however improvements had not been made in relation to people's safety, assessment and review of risk and accident and incident procedures.

The registered manager at Homelea had been registered with the CQC since June 2017; however they had been absent from the home for approximately six weeks. A deputy manager employed around this time was in day to day charge of the home supported by the provider. The registered provider, manager and acting manager had failed to follow safeguarding protocols for reporting accidents and incidents. We found eight examples of safeguarding incidents which had occurred in August and September 2017 which had not been reported to the local authority. We also identified three further safeguarding issues which needed to be reported, we asked the provider to do this during the inspection. We asked the provider to look at all previous accident, incidents and falls to ensure any further reports which needed to be made to the local authority were completed immediately. We shared our concerns with the local authority after the inspection.

Staff told us they had received safeguarding training, and that they were aware of their responsibilities to keep people safe. All staff told us they would pass concerns onto a senior member of staff who would take any actions needed. Staff did not demonstrate an understanding around recognising and reporting accidents/incidents and falls appropriately and this placed people at risk. here was no guidance in place to ensure that accidents, incidents or falls were reported to the local authority or CQC if required. The provider and deputy manager were not aware of the correct reporting guidelines. We found accidents, incidents and falls documented in the staff communication book and daily records which did not have an accident or incident form completed. We found accident forms which did not have a corresponding body map completed and two body maps had been completed without a corresponding accident or injury form, therefore information regarding injuries was not being clearly recorded. Some accidents, injuries and falls including an unexplained bruise which inspectors identified during the inspection had not been documented or reported to show actions taken. When we asked staff and management about injuries people had sustained we received conflicting explanations. Staff had made assumptions regarding how any injuries had occurred and had failed to complete any documentation or report the injury to the acting manager. Procedures to respond to accidents/ incidents and falls were not being followed. This left people at serious risk. The provider had failed to ensure peoples safety was being maintained at all times. The above issues meant that people's safety had not been assessed or maintained.

There was not enough staff to provide safe and appropriate care and support for people. We looked at staffing rotas and spoke to staff. Staffing levels had not been reviewed in light of the high number of incidents that had occurred over July, August and September 2017, many of these had been recorded as unwitnessed. Staff told us they were very busy, rotas showed that that four care staff were on duty in the morning; this included a senior who was responsible for medicines and other senior role duties, one member of care staff was designated to assisting in the dining room with breakfast and providing drinks to people throughout the morning. This left two care staff to attend to people's care and support needs. As some people required two staff to support them during personal care for example, ensuring there was adequate staffing in communal areas at all times was difficult to manage. Some people had behaviours that may challenge and needed a high level of support. Visitors told us staff often appeared busy. At night there were two care staff to provide care to everyone. People had a high level of care and support needs, including people with dementia who needed support at night to ensure their safety was maintained. Due to peoples high level of support needs, staffing levels were not adequate to ensure everyone's care and support needs were met in a timely manner and people were kept safe at all times.

During the inspection we saw that the acting manager, provider and manager from another service had to provide cover in communal areas or respond to call bells. The provider told us people's care needs were reviewed using a dependency tool. We saw that these had been completed in people's individual files. However there was no evidence how this information was collated together to determine safe and appropriate overall staffing levels to meet people's needs.

People with identified health needs did not have clear information recorded in their care files. We found that for some health needs, for example in relation to nutrition or continence, care plans had not been updated when changes had occurred. One person had a change to the way their meals should be provided after a review by Speech and Language Therapist (SALT). We found a letter in the rear of the care folder from SALT with guidance for staff to follow. However, this information was not recorded on the persons care plan for nutrition. The impact of this was reduced as kitchen staff were aware of the need for pureed or soft meals for people and they were responsible for serving up meals for people. When care staff provided food or drinks for people at other times staff told us they would seek advice from the cook regarding how people's food needed to be given, for example soft or pureed. When the cook was not available staff said they would look in the care plan for guidance. Information in care plans was not accurate, or updated when changes to peoples nutritional needs had occurred. People were at risk of receiving inappropriate support in relation to their nutritional needs. One person had specific continence needs. They were at risk of receiving unsafe and inappropriate care and support as staff told us they would have to ask other staff for guidance. Accurate information had not been updated in their care plan to inform staff how to provide safe care at all times. The above issues above meant that the provider had not ensured people received safe care and treatment. This is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in January 2017 medicines procedures needed to be improved. Although some of the specific medicine issues identified had been addressed some further issues were found. People had been prescribed medical creams to be applied by staff, there was no guidance to inform staff where and how to apply these creams. Staff told us where they thought creams should be applied but there was no system to ensure creams were being applied correctly. No information had been recorded in people's care plans regarding topical creams. Therefore there was a risk that some people may have had creams applied incorrectly.

Some people had been were prescribed 'as required' (PRN) medicines and protocols were in place for these. People took these medicines only if they needed them, for example if they were experiencing pain. Some

PRN medicines were for '1 or 2 tablets' as required. Staff did not always record how many tablets had been given. For some PRN medicines, the reason why these had been given had not always been recorded on the back of the Medicine Administration Record (MAR) chart. Staff told us they would ensure this was consistently completed in future. Where people had been prescribed PRN medicine for anxiety or behaviours that may challenge there was clear guidance about how people may present and when to give this medicine. Where people had been prescribed paracetamol there was clear guidance about when this should be given and why, however there was no information about the time interval between doses but staff demonstrated a clear understanding of when this should be. There were systems in place for ordering, receiving and disposing of medicines.

Staff demonstrated a good understanding of how people liked to receive their medicines. If a person declined their medicines, staff told us they would return a little while later and try again. Staff were able to tell us that one person always liked their morning medicines late and they knew specific information about people and their medicines that was not recorded within people's care plans. This meant that the impact was reduced. For people who received their medicines covertly staff were able to tell us how this would be done. However, this information was not documented. Covert medicines means medicines are crushed or placed within food or drinks to disguise them. We saw that a GP letter stated they agreed to the medicines being crushed and given covertly to an individual. Crushing medicines may alter the way they work and make them ineffective. Staff should always ask for a pharmacist's advice before they crush any medicines. We were told a pharmacist had been consulted in relation to this person's medicines, however this information could not be located during the inspection to confirm this had taken place. Medicine bottles were dated when opened and discard dates were written on them. However, for topical creams, staff told us they thought dates were written on the boxes, which then got thrown away. Staff told us they would ensure this was reviewed and dates would be applied directly to the container in future to ensure topical creams were not kept past the stated use by date.

Improvements had been made to infection control procedures. However, some areas required further attention to detail. We found two beds which had been made which had soiled bedding. We monitored this throughout the morning to see if staff changed the bedding and we found this did not happen. We showed this to the provider who ensured this was addressed immediately. Staff wore appropriate protective clothing when providing personal care or when assisting with food preparation. People's rooms had been cleaned and laundry areas were tidy and organised. There were on-going improvement plans to update the decoration in the home to improve the overall environment. New furniture had been purchased in people's rooms and there were plans to redecorate the main communal lounge and other communal areas of the home.

Maintenance issues were responded to and details of emergency contacts available in the event of water, gas or electrical issues. Systems were in place to check equipment and services were well maintained. These included amongst others, gas, personal appliance testing (PAT) and legionella checks. We saw that the electrical certificate had identified work was needed. The provider assured us this had been completed, however no documentation was available to confirm this. A fire risk assessment dated 2016 had highlighted works needed but nothing which was classed as urgent, a more recent fire risk assessment had been completed, the provider was awaiting a report to be sent. 'In house' fire and health and safety checks were documented weekly and monthly by the maintenance person or management.

People were protected, as far as possible, by a safe recruitment practice. Recruitment information included application forms, identification, references and employment history. The provider was aware that for future recruitment one reference should be from the most recent employer. Each member of staff had a disclosure and barring checks (DBS), these checks identify if prospective staff had a criminal record or were barred from

working with children or adults. This meant that as much as possible people had been assessed as safe and appropriate to work within a care setting.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in January 2017 the provider was requires improvement in effective and there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that treatment provided reflected people's preferences or individual needs. There was a lack of choice and involvement at mealtimes and when snacks were provided.

The provider sent us an action plan stating how they would meet the requirements of the regulations by May 2017. At this inspection improvements had been made in relation to choice and mealtimes and the provider was meeting this part of the regulation. However further issues relating to person centred care were identified and are included within the responsive domain in this report.

People told us what time they liked to get up and where they liked to eat their meals. One person told us, "I stay in my room until I'm ready." Staff told us people's preferences with regards to what time they liked to have their breakfast and how they liked to take their medicines. Despite this we found that there were concerns in relation to consent and how decisions were made in relation to people's care and support.

At the last inspection we asked the provider to seek guidance on Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) and to take action to update their practice accordingly. At this inspection appropriate actions had not taken place and the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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). We checked whether the service was working within the principles of the MCA and whether conditions on authorisations to deprive a person of their liberty were being met.

Although staff were able to tell us about the principles of DoLS and MCA, we found that there was minimal or no information recorded in people's care files to inform staff if a DoLS was in place for people. The provider and acting manager told us they were in the process of going through files to look at DoLS but were unable to tell us what specific decisions DoLS had been requested for in relation to people's care or what authorisations were currently in place. Staff told us if they needed clarification they would look in people's care plans. However relevant information was not recorded in care plans to ensure staff could access this information when needed. For example we were told one person had a DoLS authorised but staff were not able to tell us what restrictions this specifically related to. Relevant information and guidance was not in place in relation to decisions made.

Care files also included conflicting information regarding who had an authorised power of attorney (PoA). When a person is a legally authorised PoA this relates to care and welfare and/or finances. Information regarding a person's PoA must be clear to inform staff who is legally entitled to be involved in specific decisions regarding that person's care. One care plan included an email from a family member informing the home they did not have PoA for finances, only health and welfare; however the care plan said they did. We asked the acting manager and provider for clarification and they were unable to provide this.

When people were in their bedrooms not everyone had been given their call bells. Staff told us that not everyone was able to use them; however there was no information to show how this decision had been assessed or what alternative methods had been considered. Some people had pressure mats in their rooms. These are used to alert staff if a person is moving around their room, however, there was no rationale for why pressure mats were considered the most suitable and appropriate method to ensure peoples safety. Risk assessments had not been completed to demonstrate the mats had been assessed as necessary. There had been no consideration regarding each person's capacity or consultation with the person or their legal representatives. Staff told us the mats alerted them to when a person stood up from their chair or got out of bed so that they could go to the room and sit them back down or help them return to bed. People were at risk of restrictive practice by staff as appropriate checks and reviews had not been completed. The above issues meant that the provider had not ensured care and treatment was provided with the consent and involvement of relevant persons. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that they would receive care and support from staff that had received all of the appropriate training they required to enable them to work effectively in their role. We found examples of staff administering insulin to one person in the home for diabetes without having their competency to administer insulin assessed by an appropriate healthcare professional. The administration of insulin to manage people's diabetes is a task that requires the formal delegation of duty from a nurse or suitably qualified medical practitioner. Staff had not had their ability to administer this medicine assessed and the provider had not ensured that staff administering this medicine were competent to do so. We raised this with the registered provider and acting manager of the home who immediately made contact with this person's GP in order to arrange for District Nurses to administer this person's insulin until staff had been assessed as competent to do so by an appropriately trained clinician. This meant the impact was reduced. The provider assured us that insulin would not be administered by staff until appropriate training and competencies had taken place.

We looked at staff training overall and saw the provider's training programme which included amongst others, moving and handling, health and safety, fire awareness, infection control, MCA/DoLS and dementia training. There were gaps in training which we were told by the provider and acting manager were in the process of being addressed, with future training dates set. Training information only included those that had taken place in 2017, so it was not possible for us to determine if any other training had taken place. The deputy manager did not demonstrate that they were aware of who was out of date with training or who required training in the near future. The provider told us they reviewed training and would follow up with staff if they failed to attend. General medicine competencies had been assessed; however this had not included competencies regarding insulin administration. As this issue had not been identified by the provider this person had been at risk of receiving their insulin in an unsafe way, by staff who were not appropriately trained or assessed as competent to do so.

New staff received a period of induction. This included a tick chart used to ensure all staff were aware of the policies and procedures for the home. An induction book was then given to the new staff member which they worked through with senior staff. Inductions included shadow shifts and management observations

although, these were not always documented. Anyone new to care would be expected to complete the Care Certificate, although the acting manager told us they always tried to employ staff who had previous care experience. We spoke to a new member of staff who told us they felt supported and competent as they had previous care experience and were now getting to know people's care needs. They told us they had worked alongside another member of the team providing 'double ups' when people needed two staff to assist them and this had been a good way to get to know people's needs.

Staff received supervision, a supervision record had been completed when this took place and this was signed by the staff member and person carrying out the supervision. The acting manager told us the plan for supervisions was that they would take place every two months. Although future dates had not yet been scheduled, we saw that supervisions had been taking place over previous months.

People's nutritional needs were met. We met the cook who had worked at Homelea for approximately nine months. They were able to tell us about people's food preferences and specific nutritional requirements, for example, people who required diabetic or fortified meals and who had pureed/soft diets. There was a menu for the main meal and supper meal and there were two choices at each meal. For breakfast, people were given a choice of cereals, toast and eggs and they could eat where they chose, some staying in the dining room and others choosing to eat in their room or the communal lounge.

The four week menu plan was on the wall, and the menu for the day was displayed on a white board. The cook told us they always made extra meals than the number required to ensure that alternatives were in place if people changed their minds. At lunch time most people came into the dining room. Two people who needed support stayed in the lounge but were sat together. People could choose where to sit but most sat within friendship groups. Tables were nicely set. Staff explained to people what their meal was as they served it, and if they wanted an alternative this was provided. People were offered gravy with their meal and a choice of soft drinks. Where appropriate, people were supported to have their food cut up. One person wasn't eating, staff asked if they would like the meal cut up, but the person said 'no.' The staff member then offered to assist them further and the person accepted this help.

Another person said about their meal, "I don't know what this is, I didn't order it." Staff told them what the meal was and the person said they had not ordered it. Staff offered an alternative; the person declined and happily ate their meal. People who needed support with meals had support provided and those who required pureed meals received them. When people had finished their meal staff asked them if they had enough to eat. The cook had made cupcakes for people's afternoon snack and told us homemade snacks were available every day. A selection of soft drinks were available in the lounge at all times and these were replenished when empty. People were offered hot drinks at tea and coffee time and at other times when they requested them.

There was some confusion regarding diabetes care plans. Within computerised care plans which we were told staff were using we found that the diabetes care plan stated one person had insulin each morning and to check blood sugars each day. However, the care plan had no information about what the acceptable blood sugar levels should be for this person. There was some generic diabetes information but no specific information for this person with regards to GP or health professional guidance regarding appropriate high or low blood sugar levels for them. There was no information for staff to inform them how the person presented when their diabetes was unstable. For example, did they become tired and agitated, or become confused and look unwell. There was no information to support staff regarding appropriate actions they should take if levels were not within this range or they identified any concerns. We asked the provider to ensure that all actions were updated to ensure staff were aware and had supporting information to enable them to provide effective care. This needed to be improved.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in January 2017 we found that the provider was requires improvement in Caring and there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured people's dignity and privacy was considered at all times.

At this inspection staff approached people in a kind and caring manner, and spoke to people in a way that afforded them privacy. For example, when asking people if they needed the toilet. We found the breach of regulation had been met, however, further improvements were needed to ensure people were consistently involved and supported appropriately at all times and dressed in a manner that meant their preferences and dignity were consistently supported.

People told us that they were looked after by staff. General feedback from people included that staff were caring and helped them when they needed it.

Choices around clothing people were wearing was inconsistent, we saw that ladies wearing skirts were all wearing ankle socks. There was no information recorded in care plans to show whether this was their personal choice or preference and staff were unable to tell us if this was people's choice. Some men were wearing socks and others without, again with no rationale as to whether this was their choice and no information documented in daily records to provide an explanation. One relative told us their loved one wore the same clothes each time they visited. They now visited more often and took their clothes home to wash. It was not documented in the care file whether this person chose to wear the same clothes. This was an area that needed to be improved.

Staff interacted with people in a positive manner. Staff who had worked at Homelea for some time knew people well, and spoke to them using their chosen name and communicated readily with people. There was a reliance on information being shared verbally amongst staff which could lead to people's choices and involvement not being clear. New staff told us they got to know people during their induction by working alongside current staff and asking questions about people. As care plans did not include detailed information about how people wished to be supported, there was a potential information could get misinterpreted or forgotten.

Visitors told us they were happy with the way staff provided care. All visitors said that staff were caring, but there were minor gripes, including people's clothing, and the loss of items including a person's dentures.

People approached staff freely and were happy to see them. Staff maintained eye contact when talking with people and offered appropriate physical contact, for example, one lady liked to hold staff by the arm whilst walking. Another liked to show affection to staff, this was supported whilst remaining appropriate.

Staff complimented people on their appearance. We heard one staff member say, "Hello, you look handsome today." "That's a nice cardigan." When a person became visibly distressed, staff offered words of

comfort and tried to distract them, whilst reassuring them their relative would be visiting later. At lunch time one person wanted a shower and was quite anxious it should be done. For them, it was more important at that time than dinner, this was supported and the person returned after their shower to eat their meal and appeared relaxed and happy.

Records were currently stored in a lockable cabinet. Care records were in the process of being changed to a computerised system. Staff had hand held devices to input information about people's care. These were password protected to ensure confidential information was kept securely.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in January 2017 we found that the home was requires improvement in responsive and there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured people received person centred care based on their individual choices and preferences.

The provider sent us an action plan telling us that these issues would be addressed by April 2017. However, at this inspection improvements had not taken place and the provider remained in breach of this regulation.

Activities were at set times. Although there was an activities person employed, they only worked part time hours; this amounted to three activity sessions a week. External entertainers visited one morning a week and people told us they enjoyed this. People had limited access to things to do, or sensory items, books or crafts in communal areas. There was no table in the communal lounge, so when people were writing, colouring or trying to do a jigsaw, they had to do this using small individual chair tables next to where they were sat in an armchair. This did not afford people with any opportunity to do activities together; each person was doing their own thing, with limited interaction between people. People were seen to fall asleep whilst sat in the lounge and there was limited interaction taking place. Using small tables was not comfortable or practical for some people due to their restricted mobility. Staff provided general support but told us they did not have much time to support activities. We observed on both days of the inspection that the television was on in the main lounge area most of the time. This was only turned off when a visiting entertainer was in the building or a set activity was taking place. The volume on the television was turned fairly high and subtitles were showing on the screen. Staff told us they put the television on when people were in the lounge, however it was unclear who was actually watching the programme and people were not asked what they wanted to watch. We noted that the layout of the main lounge meant that many people sat in the lounge did not have a direct view of the television.

Care was not provided in a person centred manner. There was limited information to demonstrate how care and support was provided in a way that met people's preferences and choices. The provider had not ensured that people's care and support needs had been assessed planned and reviewed in accordance with their preferences and wishes. Records did not provide staff with information to ensure peoples individual care and support needs were being met.

The provider told us about planned improvements to documentation. This included a new computerised system which was in its infancy. The provider told us that staff could access information on their hand held devices. However, not all care information had been implemented for all people living at Homelea and staff repeatedly told us they used the paper care documentation if they wanted to find out information about people's needs. As this information had not been maintained and lacked person centred or specific information about people and their choices or preferences the provider had not ensured staff working within the home had access to up to date relevant information. Newly written computerised care plans had been written without the involvement of the person or representative and information was generic and comprised of tick boxes. Limited person centred information had been included. Although we appreciate

this was a new system, the provider told us staff were using the computerised care plans to inform them about peoples care needs.

The above issues did not show that people received person centred care based on their individual choices and preferences. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints policy and procedure was in place and displayed in the entrance area and included as part of the home's statement of purpose. The provider told us there were no current complaints being investigated. However, there was no information to show how issues raised with staff were being explored. For example, one visitor told us they had raised an issue with staff on more than one occasion regarding their loved ones clothing; however, the provider was not aware of this issue. People told us they normally discussed issues with care staff. The provider assured us that staff would be reminded that all issues even minor should be documented so that an audit trail is in place to evidence issues were being addressed and responded to.

Health professionals told us that they were contacted when there were concerns; however this was not consistently documented so we were unable to evidence if this was always done in a timely manner.

Inadequate

Is the service well-led?

Our findings

At the last inspection in January 2017 we found that the provider was requires improvement in Well-Led without an identified breach, as new systems and processes needed time to become fully embedded into practice. At this inspection we found that improvements had not become embedded and the provider was now in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was currently a registered manager at the time of the inspection the registered manager had been absent for a period of sickness. Since the inspection we have been informed that they are leaving the service and are de registering as manager. A deputy manager had been employed and had started the day the registered manager had started their sick leave. The deputy had been left in day to day charge of the home and the provider had not maintained suitable oversight to ensure good governance of the service had been achieved and maintained. Since the inspection we were informed that the deputy manager had left employment at Homelea and the registered provider would be registering as manager at Homelea.

People told us they knew who the owner was but that the manager was off sick. Staff told us they would speak to the deputy as they were the one in charge at that time. Although the provider visited the service regularly they had not maintained oversight of the systems and processes.

Audits and analysis had not been completed robustly, actions had not been addressed, and some areas of the day to day running of the home were not safe. Auditing although completed, did not identify all issues found during the inspection. The registered manager and provider had not identified a number of areas which did not meet regulatory requirements. Current auditing systems had not identified issues in relation to care planning, staff levels, accidents and incidents, reporting to external agencies, lack of appropriate risk assessments, care reviews, MCA, DoLS, changes to health and care needs and Power of Attorney (POA) details not being accurately documented for people living at Homelea.

An audit had been completed by the pharmacy providing medicines to the home. This had been done in June 2017 and had identified areas that needed to be addressed with regards to appropriate storage of some medicines. The deputy manager was unable to establish if any of the actions had been addressed, therefore a new audit had been requested and had taken place the week before the inspection. The deputy manager told us they were still awaiting the report to be sent to them and they were not aware if issues had been identified. This did not demonstrate adequate provider oversight of medicine processes and procedures.

The lack of robust quality assurance meant that the registered provider had not identified a number of gaps and omissions in records in relation to people's care and associated risk. Care records had not been maintained to ensure they were accurate, complete and contemporaneous. We found examples when documentation was not updated or reviewed sufficiently and this meant information about people's care and support needs was inaccurate or incomplete. This included information regarding their recent falls, accidents, incidents, injuries, nutrition and care needs.

There was an over reliance on staff sharing information verbally and information was not being documented. This included, changes to a person's continence identified in reviews over two months. This person's care plan had not been updated to reflect these changes; this meant that staff did not have the appropriate information to ensure this person's continence was safely managed. People's weights were monitored but information regarding referrals and actions taken by staff in response to people's weights had not been consistently documented. Nutritional assessments for one person recorded them as at low risk. However, the assessment which took place in May 2017 took into account April's weight loss but this assessment score had not been added up correctly and the risk should have been calculated as medium instead of low. The provider and acting manager told us what action had been taken in response to this person's weight loss but this was had not documented within their care plan to we were unable to confirm this.

There were items of documentation we were told had been completed. However, this could not be located by the registered provider or acting manager. This included some DoLS, PoA, falls and medicines documentation. This meant we were unable to evidence if the provider had completed required actions. Daily records and handover documentation did not include relevant information, for example after incidents or changes had occurred. Relevant information regarding people's individual mental capacity and decision making had not been completed or updated when changes occurred. Care files lacked information to ensure people's care was delivered in accordance with their wishes and preferences. Documentation had not been maintained to reflect people's current care and support needs. Relevant information regarding care and support needs did not correlate across corresponding areas in care files. The above issues had not been identified as part of the providers auditing and governance at Homelea.

Issues in relation to maintenance work required or carried out was unclear, for example water temperatures and electrical checks identified works required and although the provider told us they believed these had been addressed, insufficient information had been recorded to evidence if work had been completed.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As the provider had not ensured good governance had been maintained.

The most serious concerns found during the inspection were regarding accident, incidents and falls. Systems for auditing of accidents and incidents were inadequate and did not ensure that appropriate preventative measures were taken to reduce occurrences. There had been a lack of reporting of incidents and accidents to the local authority and CQC over previous months, with a number of reportable incidents identified by inspectors during the inspection. The registered provider and acting manager did not demonstrate an acceptable level of understanding or knowledge regarding their responsibility to report appropriately which meant that people were not being protected and safeguarded. Accident and incidents had been listed monthly up until June 2017. However, this did not include suitable analysis or audit of accidents and incidents completed to identify any actions or themes which may need responding to.

The provider told us that the registered manager had oversight of accidents, incidents and falls. We saw that one type of analysis had been completed by the registered manager up to the time they became absent from the home, and a different analysis process had been completed by the deputy manager for July and August 2017. However this did not include relevant information regarding the accident or incident. Despite there being a high number of unwitnessed falls, accidents and incidents, analysis did not show any trends or actions identified or demonstrate how any learning had been taken forward from incidents that had occurred. We found accident and incident forms for July, August and September 2017 which had no evidence of manager oversight or review to identify if any further actions had been needed or taken place. Some forms had no signature on them by staff or management and information was not clearly recorded to

show what had actually taken place.
The provider had not notified CQC without delay of incidents and injuries which had occurred to people living at Homelea Residential Care Home. The above issues are a breech of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Staff meetings and supervision had taken place and there were minutes available for people to read if they had been unable to attend. Minutes showed discussion had taken place regarding staff roles and responsibilities and at two meetings in August and September 2017 management had informed staff that documentation needed to improve, there was no follow up information regarding how this was to be actioned. We were told that attendance at meetings had been low and the provider was looking at ways to address this concern.

Feedback from people's relatives had been sought over recent months; however feedback received did not lead to any documented actions. The registered provider told us they were sure that issues had been responded to but no evidence was seen to confirm this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the commission without delay of the incidents which occurred whilst the service was being provided in the carrying out of a regulated activity. 18(1)(2)(a)(i)(ii)(iii)(b)(ii)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured choice was considered that met people's needs and preferences. 9 (1)(a)(b)(c)(3)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care and treatment was provided with the consent and involvement of relevant persons. 11(1)(2)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care, treatment and risks to people had been assessed and mitigated. 12(1)(2)(a)(b)(c)(g)(i)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance had been maintained. Systems and processes were not in place to assess, monitor and improve the quality and safety of the service provided. The provider had not maintained accurate, complete or contemporaneous records in respect of each service user. 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

Warning Notice