Imperial Healthcare (UK) Ltd

Homelea Residential Care Home

Inspection report

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Date of inspection visit:
16 January 2017
17 January 2017

Date of publication:
08 March 2017

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

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 independently mobile and 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 25 people living at the service.

This inspection which took place on 16 and 17 January 2017 and was unannounced.

Homelea Residential Care Home was taken over by a new provider in August 2016. The previous registered manager had stayed in post at the home and had registered as manager under the new provider. 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.

At the time of the inspection the registered manager was absent for a planned period of time. During this period acting managers had been employed but currently the day to day running of the home was being overseen by the provider who told us they would remain in day to day charge until the registered manager returned.

Since taking over the service the new provider had carried out audits and identified a number of areas which needed to be improved. Although some new systems and documentation had been started this had not become fully embedded into practice. New documentation to record people's daily care and support had not been fully completed by staff; this meant it was difficult to get a clear picture of how people were receiving care each day. Daily records were task orientated and did not consistently include details of people's mood and behaviours or how they had spent their day. Some just stated 'Fine' or 'Well.' Other information was completed using tick charts to show care tasks carried out. Information was not person centred and it was difficult to follow the rationale behind some decisions that had been made.

Medication systems needed to be improved. We found topical creams which had prescription labels removed and creams which had been prescribed to a named person were found in other people's ensuite bathroom and bedrooms.

Infection control best practice was not being adhered to by care staff. Staff did not wash or disinfect their hands in accordance with infection control guidelines to prevent the spread of infection.

We saw examples that demonstrated that staff had not considered people's privacy and dignity. Staff spoke

across communal areas regarding peoples care needs. Staff were not seen to respond in a timely manner when people requested assistance.

There was a four week menu displayed. There was one main meal choice but if people did not like this, alternatives would be provided. Mealtimes were chaotic and people did not receive appropriate support to ensure they ate and drank their meals. Staff did not speak to people to inform them what they were eating and when alternatives were requested staff did not ensure that this was responded to effectively.

Systems to record accidents and incidents were not being followed to give accurate details of incidents, injuries and actions taken. Body maps were not consistently completed. No information was in place regarding wound sizes and some documentation was not dated or signed.

Activities were taking place; however at times when visiting professional were not at the home, staff were responsible for providing this. A new staff member was due to have further training to assist in this role. We found that people in their rooms were at risk of becoming isolated and apart from the television and music access to meaningful activities was limited.

Staff had an understanding about how to recognise and report safeguarding concerns. Staff were clear that any concerns would be reported to the senior or manager. Referrals were made appropriately to outside agencies when required. For example GP visits, community nurses, chiropodist and speech and language therapists (SALT). And notifications had been completed to inform CQC and other outside organisations when events occurred.

Systems and plans were in place for the maintenance of the home, equipment and services.

There was a programme in place for on-going refurbishment of people's rooms and communal areas. New furniture had been purchased for the lounge and new carpets and red oration was in progress in the hallways.

Recruitment systems had been reviewed to ensure future recruitment systems were robust. Staff received supervision and appraisals. Staff meetings had taken place to improve communication. Staff told us they enjoyed working at Homelea. Training had been reviewed and a new training programme was in place. Staff had received training in relation to the Mental Capacity Act (MCA) and had an understanding of Deprivation of Liberty Safeguards (DoLS). However decisions around people's capacity needed to be improved to ensure that the rationale behind decision was clear involving people or their representatives as appropriate.

Relatives told us they felt happy with the care being provided and could see that improvements were in progress.

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

The service was not always safe.

Risks to people had not been identified and appropriate documentation put in place to ensure people safety was maintained at all times.

Medication procedures were not being consistently followed to ensure people received their medicines safely and consistently.

Accident and incident processes were not embedded into practice

Staff had not ensured that safe infection control measures were followed at all times.

Systems and plans were in place for fire safety and emergency evacuation.
There was a programme in place for on-going refurbishment of people's rooms and communal areas.

Recruitment systems had been reviewed to ensure future recruitment systems were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt they had enough training to carry out their roles and responsibilities however; we found gaps in their knowledge and understanding.

Newly recruited staff required further support to ensure they were suitably trained and confident to provide care effectively.

Peoples nutritional needs were reviewed however people's choice and support at mealtimes needed to improve.

Staff had training in relation to the Mental Capacity Act (MCA) and had an understanding of Deprivation of Liberty Safeguards (DoLS). However decisions around people's capacity needed to be improved.

There were close links to a number of visiting health care professionals and people were able to access health care services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always demonstrate consideration to people's privacy and dignity.

The rationale behind decisions made by staff was not clear.

People were not responded to in a timely manner when they requested assistance.

People told us that they liked staff and that they felt looked after.

Relatives told us that they felt that on-going improvements were taking place.

The provider had identified further improvements needed in relation to people's dignity and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care documentation and decisions made did not show how the person or their representative had been involved in decisions made.

Care was not individualised or person centred.

Improvements to documentation was taking place however, further improvements were needed to show how people were receiving appropriate care to meet their individual needs and preferences.

A complaints policy was in place and concerns received had been responded to in a timely manner.

Is the service well-led?

Requires Improvement

Homelea had a change of ownership in August 2016. The previous registered manager had stayed in post and had registered under the new provider.

The registered manager was currently away from the service for a

planned period of absence and the registered provider had taken over the daily running of the home.

A number of new systems and audits had been implemented to improve the environment, documentation and care and support provided. However many of these changes had not yet become fully embedded into practice.

Audits needed to be improved to ensure they identified errors and omissions. And make sure that care and documentation reflected peoples current needs.

The provider had an improvement plan to make positive changes to the way care was provided.

Improvements to training provision had been implemented. Staff received supervision and meetings had taken place to improve communication.

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.'

This inspection which took place on 16 and 17 January 2017 and was unannounced. The inspection team consisted of two inspectors.

The service provider had changed since the last inspection at this location. The new provider had owned the service since August 2016.

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 any other information that had been shared with us by the local authority and quality monitoring team.

At the time of the inspection there were 25 people living at Homelea. Not everyone was able to tell us about their experiences living at Homelea due to their dementia. To gain further feedback we carried out observations including a Short Observational Framework for Inspection (SOFI). SOFI is a tool used to observe care in communal areas to capture the experiences of people who have dementia and are unable to tell us about their experiences and the care they receive. SOFI observations take place over a designated period of time to gain feedback about people's first hand experiences, staff interactions and how people spend their time. We spoke with three visitors and relatives and eight people who lived at Homelea to get their feedback about the home and what it was like to live there. We spoke with eight staff, including the provider, area manager, kitchen and care staff. We also gained feedback from two health professionals visiting the service.

We looked at care records for four people to get a picture of their care needs and how these are met. We also looked at documentation in a further three care files to follow up on specific health conditions and areas of care for people, including risk assessments. All Medicine Administration Records (MAR) charts were checked and medicine storage and administration was reviewed. We read daily records and 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

Peoples told us they felt they were looked after and that staff were there to support them when need. Relatives told us, "They are safer here; I could not keep them safe any longer at home."

Since the new provider had taken over the service there had been a number of changes to care documentation including risk assessments and care plans. We found that these changes had not yet become fully embedded into practice. There were a range of individual and environmental risk assessments in place. However, risk assessments were not in place for all risk and not all risks had been identified. One care plan had not identified risks in relation to the person mobility.

Care documentation and risk assessments were not in place to inform staff of peoples specific health needs, this included diabetes, catheters, and blood clotting medications which may put them at further risk if side effects are not recognised and understood. We observed that moving and handling for people who had fluctuating mobility needs had not been risk assessed and reviewed. Changes to needs had not been well communicated to care staff and we witnessed inappropriate use of moving and handling equipment during the inspection. People had not been reviewed and assessed to ensure that equipment was appropriate to use for them and that there safety was maintained at all times. One person staying at Homelea for a period of respite required assistance by staff and the use of a stand aid. Staff told us they used this as this was the equipment the family used at home for this person. However, no assessment had been carried out by the provider to ensure this was appropriate. We saw that in the morning staff helped the person stand using the stand aid by lifting them under their arms. No handling belt was used. Handling belts are designed to assist people when they are able to weight bear but just require support from staff and should not be used to lift people. Later we saw that staff assisting the person used a handling belt, however this was not used safely and had not been properly fitted to the persons waist. The belt was used to lift the person from the chair to a standing position. When the person was unable to stand using the stand aid a number of staff were called to assist. The moving of this person was poorly managed, with staff offering various advice and instructions which led to confusion amongst staff regarding what they needed to do. When this person needed to be assisted to move again later during the inspection, staff were overheard in the communal lounge providing conflicting opinions regarding how this should be achieved. This meant that risks to people's safety had not been maintained.

There was a system in place for the recording of accidents and incidents. Staff told us when people had falls that they completed a form and it was given to the manager. We found that some recent incident forms were in the medication room as they had been given to the team leader and others were given to the provider. The provider told us that they should be informed of any accidents or incidents that had occurred and appropriate follow up actions took place and was documented. We identified recent accident/incident forms and found that these did not contain all information regarding wounds and actions taken after the incident occurred. For example one person had a body map dated 3rd January 2017 which stated that they had a cut. There was no information regarding the whether this had been a witnessed incident or fall, what size the wound was. Daily records indicated that this had been referred to the community nurses however no further information had been completed regarding future treatment or actions needed. Another incident

form was dated 6 January and was completed for 'a small skin tear on left elbow'. However, no mention of any incident or injury had been included in the daily records on this day and no body map had been completed to document what had happened. We found further examples of inconsistencies between accident /incident forms and people's daily records. This meant that the response to accidents and incidents was not consistent. Actions had not been documented to ensure learning from these incidents and to show how the home had responded to incidents to help prevent them re-occurring.

When people were in their bedrooms they did not have access to their call bells. Staff told us that not everyone was able to use them; however it was not clear how this decision had been assessed. When people were sat in the communal lounge there were no portable call alert systems in use. This meant that when staff were not in the lounge people had to call out to alert staff that they needed assistance to the toilet or wished to have a drink. When in their rooms people who could use a call bell had not always had this placed within reach to ensure that they could call for assistance if needed and told us they usually just shouted if they needed anything. People had sensor mats placed in their rooms at night to alert staff if they got out of bed.

Medicines were not always managed safely. Medicine Administration Records (MARs) were inconsistently completed at times, which made it difficult to tell if some people had received their medicines as prescribed. Protocols were in place to support staff to administer medicines to people on a "when required" or PRN basis, however we found that some details were missing from these, and staff had not always documented on the rear of the MAR chart when and why it had been given. This included Oramorph which is a pain medication. Some PRN medications also had highlighted times in the MAR chart; this is not consistent with PRN being given 'as and when required' as prescribed. We found topical creams and medications kept in people's rooms had not been appropriately stored. A tube of Algesal cream which is used as a topical analgesic was found in the beaker with one person's toothbrush in their bedroom. The tube did not have a lid on and would be dangerous if consumed orally. Topical creams including barrier creams, E45 and aqueous creams prescribed for people were found in the wrong person's room. Labels clearly indicated who the cream had been prescribed for and this did not correspond with the person's room or ensuite bathroom they were found in. We also found a further three topical creams in bedrooms which had labels removed so that it was unclear who they had been prescribed for. In the medication room there were a large number of creams stored on a shelf which had been prescribed for people who no longer lived at the home. Medication and topical creams should only be given or used for the person they are prescribed for. People were not receiving their medication in a safe and consistent manner.

Staff did not follow infection control guidelines in place to protect and prevent people from the spread of infection. We saw a staff member leave a persons bedroom after providing personal care wearing disposable gloves which they then removed and put into their pocket whilst walking to another person to provide assistance. This person was not seen to wash or disinfect their hands. Another staff member wore blue gloves to give out hot drinks and biscuits in the lounge. They were only able to find one glove so they kept this on whilst handling the food items. We saw they assisted a person to walk across the room, picked up the persons pressure relieving cushion placed this in the armchair then returned to give out drinks and biscuits without changing or removing the glove. We raised this as a concern with the provider immediately and this was addressed.

We looked at the staff rota and were told that normal staffing levels were a senior carer and three care staff throughout the day and two carer staff at night. There were also designated domestic and cleaning staff. The provider told us staffing levels were assessed and reviewed. One member of staff now started at 7am to help staff support people during the busy morning time. Staff told us this had helped. Staff felt that the needs of people had increased with a number of people now requiring two staff to assist them and others

requiring assistance with personal care, mobility and at meal times. We saw that on a number of occasions throughout the two days of inspection that people were left unsupported in the communal lounge area. Relatives we spoke with told us they visited at various times of day and had been worried that the lounge was unsupervised at times despite the fact that a number of people were in there. Due to peoples dementia, mobility and support needs it was not clear how people's safety was being managed. The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recruitment process was in place. The provider was in the process of auditing recruitment files to identify any gaps in information. We found that for two new care staff further information was needed to ensure that a robust review of their previous background and employment was in place. The provider told us that they would ensure that all future recruitment was completed robustly to ensure that this was addressed, they also informed us they would follow up on any gaps identified from more recent recruitment files. Documentation recorded that checks had been made with the
Disclosure and Barring Service (DBS) to make sure people were suitable to work with vulnerable adults. This was in place before people began working at the home.

Some items of furniture currently in use in people's rooms were broken. We found a bedside cupboard and draw unit with missing handles. A wardrobe door had come off and placed next to the wardrobe. The provider showed us that they were in the process of re furnishing peoples rooms this included new beds and furniture and this was being completed in phases with a number of rooms being renovated each month. However whilst this was taking place we asked the provider to ensure that all furniture currently in use in peoples rooms was fit for purpose and safe and they assured us this would be addressed immediately. We checked the maintenance book and saw that general repairs had been reported to the maintenance person and were in the process of being sorted.

Staff demonstrated an understanding around safeguarding people from the risk of abuse. Most staff felt that they would raise concerns with the senior carer or person in charge. Staff were aware of the whistleblowing policy, and told us that they would feel comfortable to raise any concerns with the manager or provider if they arose.

Regular maintenance and equipment checks had been carried out. These included a fire safety risk assessment, electrical (PAT) testing and water safety checks including legionella. There were personal emergency evacuation plans (PEEPS) in place to inform staff of peoples mobility and evacuation needs. A copy of these was kept by the front entrance and in peoples care files.

Requires Improvement

Is the service effective?

Our findings

Since the new provider had taken over at Homelea Residential Care Home, there had been a number of staff changes and ongoing recruitment. The provider told us they aimed to ensure that all staff were appropriately trained and experienced and understood their role and responsibilities. This had been an ongoing area of improvement and to help with this a new training plan was in place. Most recently staff had completed dementia care, safeguarding with DoLS and MCA training.

People were supported by staff who felt they had the right amount of training to carry out their roles and responsibilities effectively. One member of staff said, "I think the training has been Ok, I think I know about people's needs". Although staff felt they had enough training to carry out their roles and responsibilities we found gaps in their knowledge and understanding. Although new staff had completed a period of shadowing and induction we found that new staff working unsupervised lacked training and understanding to ensure that they provided appropriate care at all times. For example, new staff were not aware of how to use all moving and handling equipment including handling belts and were just following the way other staff did things. At mealtimes staff were seen to stand over people whilst assisting them to eat their meals. New staff was seen to follow this example and were not aware they should sit with the person to ensure that they maintained eye contact and enable better support and communication with people at mealtimes. This is an area that needs to be improved to ensure that all staff are suitably trained and competent to provide care effectively.

There was a training schedule in place which identified when staff training was due. The provider had implemented changes to the training schedule which now provided all training on an annual basis rather than some being yearly and others two to three yearly. They told us that they felt that training needed to be reviewed and refreshed and that this had been implemented as a priority. Care staff were encouraged and supported to attend further training in the form of national vocational qualifications.

Staff received support and supervisions had taken place for some staff with a plan in place to ensure all staff received supervision every three months and an annual appraisal. The provider had carried out a number of adhoc meetings with staff on an individual basis or group meetings as required. They had used one to one meetings to discuss development and to evaluate staff performance to ensure that roles and responsibilities were appropriately designated. When issues had been identified the provider had responded to this and meetings had taken place and minutes signed by the person to show discussions that had taken place. One senior carer had been given an extended role which included organisation of the medication and care staff. A new care manager was awaiting a start date and would be working alongside the registered manager.

Staff spoke with people in a kind and compassionate manner and just required a bit more confidence, support and training to ensure they provided effective care. Staff told us they enjoyed working at Homelea and "Treated people like their own relatives."

We spoke to the chef who told been working at Homelea for approximately two months. The chef was kept informed of people's dietary requirements and when people's needs changed. They were aware who

required specialist meals, for example diabetic, pureed or fortified meals. A four week menu planner was displayed in the dining room. However we saw that the lunch choice for that day was not the choice on the menu. We asked the chef who told us that they had run out of that choice and an alternative was being provided. The chef was clear that if anyone did not like the main choice that an alternative could be provided. We saw that one person did not eat their main meal and they were offered an alternative or a second dessert, which they ate.

We observed meal times on both days of the inspection. People chose whether to eat in the dining room, lounge or in their bedrooms. The dining area is split over two levels. Lunch time in the dining room was chaotic with people's meals being given to them one by one. This meant that people sat together at a table may not receive their meals together. People who required assistance or support to ensure they ate their meal did not have this provided in a timely manner. Rather than one member of staff sitting with them and assisting them we saw that staff went from person to person and this meant that meal times were not relaxed for people. Staff stood next to people and helped them take a mouthful of food then went to help someone else. When one person was left without support they were seen to pour their juice onto their plate and an alternative meal had to be provided. Some people were seen to eat very little of their meal and staff did not have the time to support them fully. When people were given their meals we heard staff tell them, 'here's your lunch' and 'eat it up its nice', however people were not told what the meal was. In the lounge one person was supplied with a meal with no explanation given regarding what it was. They were unable to cut the food themselves and had to wait for staff to notice this, when we asked what the dinner was they told us they did not know. When requested staff came and cut the food for the person, but again the person was not told what the meal was. One person who we were told had a visual impairment was assisted by staff with their meal but not told what the meal was. This did not demonstrate that care being provided was person centred.

Another person in the lounge did not eat their hot meal and asked for a sandwich, they were asked by staff what they would like in the sandwich and were offered cheese, ham or chicken. The person asked for a ham sandwich. When staff returned with a sandwich this was given to them without comment. On looking at the sandwich contents it was clear it was not ham. We asked staff what was in the sandwich and they told us they did not know. After further querying the contents staff came back and told us that they had run out of ham so had made chicken. No explanation or further choice had been offered to this person to check that they were happy with this. This did not show that staff were considering peoples choices and decisions.

Hot drinks and biscuits were provided for people throughout the morning and afternoon. We saw that people were asked if they wanted a hot drink and this was provided. If people wanted a biscuit staff chose a biscuit and carried it to the person without offering a choice. No plates were used and biscuits were put directly onto the lounge tables.

Food and fluid charts were being completed to document what people ate and drank each day. However these were not being completed at the time people had their meals and drinks, but later in the day. The provider said staff normally started completing these around 10.30am but that there may be a delay due to the inspection taking place. We asked staff to tell us when care records and daily charts were completed and we were told that they usually shared out the records so that all staff filled in about seven or eight each, but that staff did not always fill in the ones for the people they had supported. If they did not know what people had eaten or drank, or what support they had needed they would ask colleagues and 'hope they remember'. Not all records had been dated timed or signed so it was not possible to follow who had documented each record.
This meant you had not ensured that care and treatment had been provided that reflected people's preferences or ensured their needs were met. When food or drink was provided for people you had not

ensured choice was considered that met their needs and preferences.
The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to have their breakfast whenever they chose. We saw that people were eating their breakfast throughout the morning and staff told us this was flexible and depended on what time people got up. People and relatives told us that they were happy with the meals provided.

People were not always able to make their own choices and decisions about their care. We looked to see if the service was working within the principles of the Mental Capacity Act 2005 (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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in nursing and care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff had recently completed MCA and DoLS training and they demonstrated an understanding regarding capacity and DoLS. Care plans included information regarding people's capacity; however, it was not clear how this decision had been assessed as the home had not carried out mental capacity assessments. Applications had been made for DoLS authorisations when people were identified as at risk. The provider told us that capacity assessments had been completed by the DoLS team when necessary. However, the provider has a responsibility to ensure that people's capacity for everyday decisions is assessed and reviewed and this is an area that needed to be improved. For example, most people had their toiletries kept in a locked cupboard located on the ground floor. We were told this was for safety. However three people did have toiletries in their room. And a further eight had topical creams. Therefore the rationale for this decision being based on safety was unclear and how this decision had been assessed and reviewed for each person had not been documented.

Some people were unable to consent fully to all decisions about their care due to their dementia. We saw that people were involved in some day to day decisions for example whether they had tea or coffee, or what room they chose to eat in at mealtimes. However some decisions were unclear. A relative informed us that their husband did not always have socks on when they visited and they had asked staff why on previous occasions. This person was not wearing socks during the inspection; we asked staff why and received conflicting replies. One told us the person's feet were swollen and another said that the person had not wanted socks on, we asked the provider who told us they would look into this. We looked at care records for this person and could not find any information regarding this or why this decision had been made. Most ladies living at Homelea were wearing skirts or dresses and all were also wearing ankle socks. No one was seen to be wearing tights. We asked staff who told us that everyone wore socks; however the rationale behind this decision was not clear.

We recommend that the provider consider current guidance on Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) legislation and take action to update their practice accordingly.

There were systems in place to liaise and refer to other health professionals when needed and to support people to access services, this included GP's, dieticians, SALT and district nursing services. One person attended a health related appointment during the inspection supported by staff. We spoke with a visiting community nurse who told us that they visited the home regularly and were kept informed regarding

peoples care needs.

Requires Improvement

Is the service caring?

Our findings

Not everyone at Homelea was able to tell us about their experiences living in the home. Those who could told us, "They look after me, I have no complaints." And, "They are lovely." Relatives told us, "There's been some improvements, which seem to be on-going. Staff in general are very caring." And, "If I have raised anything, they have responded to it and put it right."

Relatives felt that they were kept informed when people became unwell or if they were any issues. They said that they found staff to be polite and caring, although it was acknowledged that staff appeared very busy.

We carried out observations throughout the inspection to see how staff interacted with people and how people received care and support. We saw positive examples of kind and caring support and care being provided. However staff were very task led and this was noticeable by the terminology used, for example one staff member informed another 'I'm off to do my feeds', there was no mention of who this related to. Care records were also very task led and were used to document care provided, but did not include much information regarding people's mood, or behaviours or how they had spent their day.

People's dignity and privacy was not always considered. In the communal lounge a member of care staff was heard to say to another staff member who was across the room "(persons name) is in the toilet, said to give her five minutes to do her business." This could be overheard by anyone sat in the room and did not show consideration for the persons privacy or ensure personal care was provided discretely. When people told care staff they needed assistance to go to the toilet, this was not provided promptly. We saw one person sat in the communal lounge asked three times for assistance to go to the toilet. The person sat next to them also called out to staff to inform them that this person needed the toilet. There was a delay before staff acknowledged this and assistance was provided. It was clear that this person was becoming anxious that they were not being responded to. Later that afternoon another person called out to staff to ask to return to their room and there was a delay before this was acknowledged. On a third occasion we saw that a senior staff member was writing paperwork sat in the lounge. The person next to them asked for help to the toilet. The staff member replied, Ok, then continued to write in the care folders. The person then asked again and the staff member did not respond. On the third time of asking the staff member walked across the room and asked another carer to assist the person. The above examples demonstrated that people's requests were not being acknowledged and responded to in a timely manner.

People's laundry and personal items had not been treated with respect. We looked at the laundry room and storage area. Named baskets were used for people's items before they were returned to their rooms after washing and drying. We saw that as the day progressed items were unfolded, fell out of the baskets and left on the chair and floor crumpled up. Some items were in bags on the floor. When clothes were put away in people's drawers and wardrobes they were not folded. We saw that people's wardrobe and drawers were untidy. Staff told us that people went through their drawers and unfolded items; however it was not clear why staff did not then tidy items up when they were in people's rooms.

On arrival at the home we were let into the building by the maintenance person who let us into the home

without confirming who we were. They then returned to their work leaving us by the front door. This meant we had to walk around the home to look for a member of staff to introduce ourselves. The home cared for vulnerable people and this put people at risk as no checks were made before people were let into the building. We discussed this with the provider who assured us that this would be addressed immediately. The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As peoples dignity had not been respected and maintained.

It was clear from staff interactions seen that staff who had worked at Homelea for some time knew people well. We saw some positive and friendly banter and interaction between staff and people. All staff told us they enjoyed their job and liked working at Homelea. However, staff needed further support and training to ensure that they considered peoples choices and understood the need to be discrete and maintain people's privacy and dignity at all times.

The new provider showed us further improvements they had planned around dignity to ensure that staff were aware of their responsibilities. A dignity audit was developed and the provider had carried out observations and discussions with staff to help improve the way care was provided. This was an ongoing area which they felt would develop and improve over time.

Requires Improvement

Is the service responsive?

Our findings

People told us that if they asked for help this was provided. Relatives told us that staff always contacted the GP or other health professionals when needed. One person told us, "The visitors who do activities are great but sometimes there's not much happening."

Since taking over the service the provider had responded to a number of areas they had identified which needed to be improved to ensure the service was responsive to people's needs and care was planned and reviewed appropriately. These changes to documentation were aimed at making paperwork less task orientated. However, the provider felt that changes had to be implemented slowly to ensure they were embedded properly and staff understood the changes. Some changes had been in place for a few weeks; despite this time scale staff had not fully demonstrated an understanding on how to complete daily records, accident/incident forms and daily charts accurately.

Information was not in place for all identified health care needs to show how people's individual needs had been assessed and met. For example people who were at risk of pressure damage or had reduced mobility did not have documentation in place regarding how this was being managed. Daily records did not evidence how further breakdown was being prevented and daily charts did not give a picture of peoples day or night care and support provided. For example one person had not eaten their meal and it was seen to be on their bedside table in their room. It was included in the documentation that they needed support to eat. However no information had been recorded to show how this had been met. Bowel charts indicated that some people had not had their bowels open for over seven days. No information was in place to show whether this had been raised with senior staff or what measures were in place to respond to this. Daily records stated 'Fine' or 'Well' this did not correspond when incident forms or body map had been completed.

When people moved to Homelea for a period of respite records completed were not detailed and we found that information regarding moving and handling had not been assessed and reviewed appropriately. Staff told us they were moving one person how the husband did when they were at home as that was what they wanted them to do. However once a person moves into a care environment it is the providers responsibility to assess and review mobility needs and ensure that all moving and handling is completed safely using the appropriately assessed equipment and staff support. Staff told us one person stayed in their room all day and required full assistance with all care needs. We saw that this information was included in their care plan. However no information was seen which explained why this person was unable to weight bear, why they stayed in their room in their armchair and why staff did not bring them to the communal lounge. Improved guidance was needed to ensure all staff were aware of and considered people's personal preferences, capacity and care needs before decisions were made to ensure that care was individual and person centre.

The provider told us about further planned improvements to documentation. This included new sexuality care plans to ensure they included relevant information for example, what was important to people, their personal appearance and how they liked to be dressed. Although it was acknowledged that the provider had only owned the home since August 2016 and had further improvements planned. Staff working within the home should have the understanding and skills in place to ensure people received care in a caring, dignified

and person centred manner at all times.

There was an activity schedule in place. This consisted of external organisations visiting the home each week providing dementia focussed activities for people. We were told there was no designated activities person to co-ordinate activities at other times however plans were in place for a member of care staff to have further training to enable them to become a part time activity co-ordinator to ensure that they were daily opportunities for people to pursue their hobbies and interests. Activities were at set times in the day and at other times there was limited access to any items for people to keep them occupied which they could access at their own free will to encourage them to participate in activities of their choice. In the main lounge area there were a few books and magazines on a shelf but no other accessible games, pictures or reminiscence items to provide stimulation and engage people in an activity. Staff did participate in throwing a balloon to people which people seemed to enjoy, however for long periods the television was on although a number of people sat in the lounge we in chairs that did not face the television so they were not watching it. Music was also played, we saw that in the morning and afternoon many people fell asleep as there was no activity taking place. People who stayed in their rooms told us they did not go downstairs as there was not much happening. The above issues did not show that people received person centred care based on their individual choices and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For people who were unable to access group activities and who stayed in their rooms at all times there was no structured activities taking place on a one to one basis. Staff told us they popped into check people were alright and to help them with meals and drinks and checked if they need anything, however we did not see any evidence that time was spent with people ensuring they did not become bored or socially isolated. This was an area that needed to improve to ensure that varied activities were available for people to access as and when they chose which were based on people's preferences and hobbies.

A complaints policy and procedure was in place and displayed in the entrance area and included as part of the homes statement of purpose. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. We looked at complaints received and saw that any concerns received had been acknowledged and responded to appropriately and in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

Homelea had a registered manager in post however they had been off work for some weeks and the day to day running of the home was currently being overseen by the provider. The provider was aware that they were carrying out a duel role at present, due to the fact that they were covering the management post. This had meant that they had to spend more time in the office working on the improvements. However they felt that once the care manager began their role and the registered manager returned they would be able to step back slightly and see how improvements were being implemented.

Since taking over the service the provider had identified that the home required a lot of improvement to ensure it was not only appropriately maintained to ensure a safe and comfortable environment for people, but that big changes were needed to the infrastructure of the documentation. The care plan format had been revised and a new format was being introduced. The provider was aware that this and other changes would take time to be embedded.

Staff meetings had taken place to improve communication between management and staff. Reviews of staff performance had taken place which had led to some changes of roles and responsibilities and some staff choosing to leave employment. Further on-going recruitment was still taking place with a new care manager due to commence employment once all recruitment checks had been completed.

Changes to the training format had been implemented and although this would take time to be completed the provider told us that training would be an on-going plan to ensure all staff had the training and skills to provide appropriate care for people.

Environmental improvements had been identified by the provider as a priority and a plan was in place to refurbish communal areas and peoples bedrooms. Carpets and armchairs had been changed and general redecoration of communal areas was taking place. Furniture and décor in bedrooms was in the process of being improved on a 'phased plan' of five bedrooms being updated each month. Communal hallways were in the process of being redecorated and a new maintenance person had been employed to oversee this.

There was a new system in place to assess and monitor the quality of service provided. This had only been in place for a few months and needed time to become fully integrated and embedded into every day practice. Audits in place included staff files, care documentation, kitchen, medication and nutrition. Overall analysis was completed to identify areas for improvement with actions detailed to show how this would be addressed. Some audits needed to be enhanced to ensure a detailed picture to evidence how they had been used to continually improve the service and action any areas found. For example, further auditing was needed around medication to ensure that correct procedures were being followed, for example storage and application of topical creams. Audits had identified some areas for improvement but needed to be developed to ensure they covered areas as identified during the inspection. For example, infection control procedures including observations to ensure staff were following best practice at all times.

Documentation including accident and incident forms, body maps, daily records and charts needed regular

oversight by the provider to ensure that they were being completed accurately and reflected peoples care provided. Although we could see a number of improvements which had been implemented, documentation in general still needed further improvement to ensure they reflected people's current needs. Staff required support and training to ensure they were aware of their responsibility to document care accurately and that this was being completed. Improvements to documentation and care and support needed to be under constant review by the provider to ensure it improved. This was an area that needed to improve to ensure a robust quality assurance system was in place.

The registered provider was at the home most days and spent time in communal areas and visited people in their rooms. They had got to know people living at the home and staff spoke positively of a number of the changes taking place.

Staff were aware of the policies and that these underpinned safe practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice. Staff were aware of the importance of being open and transparent and involving people when things happened. The provider was aware of the requirements regarding incidents that were notifiable to CQC and the local authority and to ensure these were always completed in a timely manner as this is a regulatory requirement.

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 9 HSCA RA Regulations 2014 Person-centred care You had not ensured that care and treatment was person centred. You 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 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and privacy had not been respected and maintained. 10(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Due to peoples dementia, mobility and support needs it was not clear how people's safety was being managed. Medication procedures needed to improve. 12(1)(2)(a)(b)(c)(e)(g)(h)