The Regard Partnership Limited

Homeleigh

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Homeleigh on 16 and 17 May 2017. The first day of the inspection was unannounced. This meant the home did not know we were coming. The service was previously inspected in September 2014 when it was found to be meeting all the regulatory requirements which were inspected at that time.

Homeleigh is a twenty-seven bedded residential care home located in the Manchester area. There were 27 people living at the service when we inspected. It is a large Victorian, detached house set in its own private gardens. The bedrooms offer single and double accommodation, with some rooms converted into flats. There is a kitchen/diner/lounge on each of the three floors. There are a number of communal bathrooms/shower rooms located near to the bedrooms that are fully accessible.

The service provides accommodation for people who require nursing or personal care and have enduring mental health needs. The fundamental purpose of Homeleigh is to support people to recover, rehabilitate and become independent.

The home had a registered manager who was previously the deputy manager. At the time of our inspection the registered manager was not available, due leave of absence. 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.

We found that medicines were not managed safely. When comparing the Medication Administration Records (MARs) with the medicines in stock we found one had not received their prescribed medicines for 16 days. Another person's strong pain relief tablet had been out of stock for two days. This meant the person would have been without their prescribed treatment if they had been in pain.

Each person receiving a service had a care plan in place. The risks identified through the provision of care had been assessed. However, we found one person's care plan and risk assessments had not be reassessed when we noted an incident in February 2017 of this person choking and requiring staff assistance to dislodge the blockage. This action had not been addressed in a timely manner and potentially put this person at further risk of choking.

Care plans did not include people's goals and aspirations. We found no evidence documented of people's setting goals and being supported to achieve them.

The fire safety management within the home required reviewing. We found people continually disregarded the homes rules of no smoking within the building. This meant the safety and wellbeing of other people living at the home and staff who worked there was compromised. We have asked the Greater Manchester Fire and Rescue Service to advise the provider on fire safety arrangements in the home.

The managers and staff understood their obligations under the Mental Capacity Act 2005 and Mental Health Act (MHA)1983 and worked within these legislative frameworks. Staff had received training in both subjects and were fully informed of any changes at team meetings to ensure they continued to provide care within the law. However, two people subject to Community Treatment Orders (CTOs) had not been informed about the reason for their CTO and their rights under the MHA.

Staff knew what action to take to ensure people were protected if they suspected they were at risk of harm. They were encouraged to raise and report any concerns they had about people through safeguarding and whistleblowing procedures.

People using the service had access to a range of individualised and group activities and a choice of wholesome and nutritious meals.

Records showed that people also had access to GPs, chiropodists and other health care professionals (subject to individual need).

The service had quality assurance systems in place, however these were not always entirely effective and did not resolve the continued discrepancies we found with medicines at the service.

We found that there were enough support workers on duty to help people meet their basic needs in a safe and effective way.

An effective process was in place for managing complaints and the home's complaints procedure was displayed so that people had access to this information. People and their relatives told us they would raise any concerns with the manager.

Incidents and accidents were recorded and analysed, and lessons learnt to reduce the risk of these happening again.

People had access to advocacy services if they needed them. The locality manager told us that the home would provide end of life care when needed and had previously spoken to one person about their wishes in this regard.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The management and administration of medicines was not consistently safe.

Risks to people were identified; however, care plans did not contain sufficient detail and information to direct staff in the management of those risks.

Sufficient numbers of suitably qualified staff were employed to keep people safe and meet their needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff fully understood their responsibilities under the Mental Capacity Act 2005 and the Mental Health Act 1983 and ensured the service worked in accordance with the legislation. However, we found two people subject to CTOs had not been informed about the reason for their CTO and their rights under the MHA.

Staff did undertake training relevant to their role and the needs of people they supported.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People's equality and diversity needs were respected and staff were aware of what was important to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Support did not focus on recovery and rehabilitation, which was the primary purpose of the service.

We found people were encouraged to participate in activities at the home.

People told us they would be confident to raise a complaint if they felt this was necessary. We saw appropriate actions had been taken to investigate complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had recognised many of the shortcomings of the service and put in place actions plans prior to our visit. These were at various stages of their implementation.

The provider did not have effective quality assurance systems and processes in place to remedy the issues identified.

Staff we spoke with told us the managers were approachable and they felt supported in their role.

Homeleigh

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

The inspection took place on 16 and 17 May 2017 and the first day was unannounced. The inspection team consisted of one adult social care inspector, one pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had personal experience of services for people with substance misuse and enduring mental health conditions.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted Manchester local authority, and Healthwatch (Manchester) to obtain their views about the quality of this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

During the inspection we spoke with 14 people who used the service. We spoke with the locality manager, deputy manager and five members of care staff. Prior to our inspection we spoke with one community psychiatric nurse who previously had a patient living at the service.

We looked around the building including in bedrooms, bathrooms, and satellite kitchens for people's use on each floor, the clinic room and in communal areas across all floors. We also spent time looking at records, which included a detailed review of three people's care records, three staff files, the training matrix, minutes of meetings; rotas; complaint and safeguarding records; medication; maintenance and audit documents.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Homeleigh. Comments included, "Feels really safe here knowing that there is always a member staff available if anything were to happen" "Very safe here and never had a problem with anything", "I feel safe, compared to where I lived previously" and "I have been here for around four years and wouldn't feel safe anywhere else."

Prior to the inspection the Commission had received information of concern that people's prescribed medicines were not always administered safely. At this inspection we found the provider had implemented a number of changes to improve the management of medicines. However we still found the service were failing to manage medications safely.

The home had a detailed, up to date medicine policy describing how medicines should be handled in the home. The registered manager carried out a monthly audit of medicines and they had already identified and told us about some concerns regarding medicines.

We observed two different members of staff giving people their medicines at lunchtime. Both staff spent a lot of time with each person while administering their medicines and gave medicines safely. However, we saw evidence that on a previous day staff had not followed the home's medicines policy and had not given medicines safely. This had resulted in a medicines error that the locality manager had acted upon appropriately. We looked at the medicine administration records (MARs) belonging to twelve of 27 people present in the home. We counted six medicines (randomly chosen) and found that the stock matched the home's records. However, when comparing one MAR chart we noted a medication called Hyoscine recorded three times for 150mcg tablets, 300mcg tablets and Hyoscine 1mg patches. We queried why this medication had been recorded on the MAR chart at three different strengths with the with the locality manager. She confirmed this would be investigated further once the registered manager returned. Shortly after the inspection the provider conducted an investigation into this matter, and we were informed by the registered manager the person did not receive their prescribed Hyoscine tablets for 16 days from 01/05/2017 to 16/05/2017. The registered manager also commented that this was partly due to an issue with the pharmacy not supplying the Hyoscine medication due to a manufacturing problem, and the GP had not prescribed Hyoscine medication in a different format. Although there had been manufacturing issues with the pharmacy, the provider had not acted in a timely manner to ensure this person received their prescribed Hyoscine medication.

Another person was prescribed 'as and when' medicine (PRN) pain relief medication that had been out of stock for 20 hours. This meant the person would have been without their prescribed treatment if they had been in pain.

Creams, including moisturising and barrier creams, were applied by staff trained to administer medicines. Records showed that people's skin was cared for properly.

Medicines were stored securely. Medicine storage facilities were clean and tidy. From the medications we

looked at we saw examples of where staff had transferred medicine from the box in which the pharmacy had supplied it to another box of the same medicine for that person. This is unsafe practice as a mistake could be made and the medicine in the second box may have a different expiry date. The temperature of the medicine refrigerator was not monitored properly because the thermometer in use was not fit for purpose. Records did not show if medicines in the fridge were safe to use. The storage of medicines at the correct temperature is important because incorrect storage may affect the stability of the medicine and they may not work as intended. This poses a potential risk to the health and wellbeing of the person receiving the medicine. Since the inspection we have been contacted by the registered manager who has informed us a fridge thermometer is now in place.

Controlled drugs (medicines subject to tighter legal controls because of the risk of misuse) were stored in the way required by law. Staff checked controlled drugs (CDs) regularly; this is good practice to prevent mishandling and to find any anomalies promptly. The locality manager told us about a discrepancy of one tablet found the previous day. We checked the amounts of the other three CDs in stock against the prescription and they matched the quantities recorded in the CD register. This assured us that people were receiving these drugs appropriately.

Prior to our inspection the Commission had been made aware of a number of issues relating to the management of medicines. These included medicines not being accounted for and missing from the clinic room and medicines not being administered to the correct person. We found the provider had attempted to remedy these issues by analysing the errors and implementing additional daily checks of the medicines along with further training for the staff who had made the errors. However, we found that these had not been effective and medicines errors were still happening. We discussed this with the locality manager who told us that they were going to restrict the job of giving medicines to ensure only the senior staff who they believe were competent to administer would now be responsible, starting the next day.

During this inspection we found concerns relating to the proper and safe management of medicines which was a breach of regulation 12(1) (2) (g), the proper and safe management of medicines, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person receiving a service had a care plan in place. The risks identified through the provision of care had been assessed. These assessments were carried out in the areas of cooking, finance, and deterioration of a person's mental health. These assessments described the risks and what action staff should take to minimise the risk of harm to the person or themselves. Staff we spoke with were familiar with people's risks and how to deal appropriately with them. We saw that risks to people at the service were regularly assessed and reviewed. General environmental and specific risk assessments were also completed. However, we found one person's care plan and risk assessments had not be updated following an incident in February 2017 of that person choking and requiring staff assistance to dislodge food. We viewed the incident report which noted the care plan needed to be updated along with a referral to the Speech and Language Therapist team (SALT). We found both actions had not been completed. We discussed this further with the locality manager who could not explain why this had not been done. During the inspection the locality manager provided the inspection team with an updated care plan on the risks of choking and evidence they had now made a referral to the SALT team. However, this action had not been addressed until the inspector brought it to the services attention and this left the person at significant risk of harm and deterioration in their health.

The provider did not take responsive action in order to keep one person safe. This is a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had Personal Emergency Evacuation Plans (PEEPs) in place and we saw these were kept in their care files with a copy in the fire manual kept in the office. A PEEP is usually a one-page summary which includes a photograph of the person, their bedroom location, how they mobilise and the number of staff they need to do so and any other information emergency personnel attempting to evacuate the person might need to know. The fire manual contained a list of people at the home that would need to be evacuated in case of emergency. We saw this list contained the names of four people who were currently not at the home due to hospital admissions, and was therefore out of date; we discussed this issue with the locality manager during the inspection and the list was amended before we left to reflect the people currently present at the home.

We saw records which showed that fire alarm practice evacuations had taken place twice in 2017; the home also kept a record of false alarms which had occurred when people smoked inside the building. The fire extinguishers at the home had been checked within the previous 12 months and we were told that night support staff completed a walk around each evening to check various safety aspects, such as fire extinguishers being in place, that escape routes were clear of obstructions and the fire doors were shut, we found this information was recorded. This meant that fire precautions and checks were being undertaken.

During our tour of the home we noted an odour of cigarette smoke from two people's bedrooms. The locality manager informed the inspection team the home was non-smoking and people had an outside sheltered area if they wished to smoke. The locality manager confirmed the staff team continually tried to enforce the rules of no smoking within the home and issued persistent rule breakers with warning letters confirming they were putting their placement at risk. We entered one person's room with their permission and noted a number of cigarette burn marks on their vinyl flooring. This person was fully aware they should not be smoking inside the home but commented, "I have smoked in my room for four years, I haven't caused a fire before, so I don't see what the issue is." The locality manager commented that the home needed to revisit the smoking situation again to find a way to get people to fully adhere to the rules to make sure the risk of a fire was prevented. We noted this person had a metal astray in their room, but found their bedding was not fire retardant to minimise the potential risk of a fire.

We have asked the Greater Manchester Fire and Rescue Service to advise the provider on fire safety arrangements in the home.

We noted the service had undergone a number of home improvements. New shower and bathing facilities had been installed on all floors. The deputy manager confirmed these improvements were still on-going and informed us that the home will soon have all the windows replaced with doubled glazed ones; we found this work had already started, and was near completion. We will check the progress of this during our next inspection.

We found policy and procedures were in place for infection control. Training records seen showed all staff were provided with training in infection control. We saw monthly infection control audits were undertaken which showed any issues were identified and acted upon. An infection control audit had been completed by the local authority in August 2015 and the service had been rated as 83% overall compliance. We saw that an action plan had been agreed to address the recommendations highlighted in this audit.

Incidents and accidents were recorded following an incident. All incidents and accidents were reviewed by the registered and locality managers. We saw the incident forms contained full details of what had occurred and what action had been taken by the staff. The registered manager noted on the forms if the local authority safeguarding team and the Commission had been notified of the incident. A monthly summary of all incidents was produced, including any actions taken, for example referrals to the falls team, so the manager could monitor any patterns or repeated issues. Risk assessments were reviewed following an

incident or fall. This meant the staff had an overview of accidents and incidents and steps were put in place to reduce the likelihood of them re-occurring.

During this inspection we saw the home was generally clean and free from malodour but some areas of the home were in need of attention. We found a strong malodour from the communal lounge. We discussed this with the locality manager who commented that staff were continually prompting this person with their personal care, but this was sometimes difficult due to the person's behaviours. During our tour of the home we noted on the first floor a strip of plasterboard was hanging from the ceiling and presented as a potential hazard. We brought this to the attention of the deputy and locality managers who took responsive action and the ceiling was repaired on the same day.

We looked at how Homeleigh was staffed to see whether there were enough workers on duty to support the people who lived there. We found that there was a sufficient number of staff on duty to meet the needs of the people using the service. Support workers either did day shifts or night shifts with hours 8am until 8pm or 7.45pm until 8am. The day shift was staffed by one senior, and nine support workers.

This was in addition to the registered manager and when she was also on duty. There was also a deputy manager, an office administrator, and a domestic worker. The night staff consisted of three support workers. The service had their own bank staff available to them to cover any sickness and annual leave, the service did not use agency staff. There was an on-call system also in place outside of office hours and at weekends. This provided the staff team with additional help and support should the need arise.

A policy and procedure had been developed by the provider to offer guidance for staff on 'Safeguarding service users from abuse or harm'. A copy of the local authority's adult protection procedure was also available for staff to refer to. Staff we spoke with demonstrated a good awareness of their duty of care to protect the people in their care and the action they should take in response to suspicion or evidence of abuse.

We checked the safeguarding records in place at Homeleigh. The registered manager was aware of her responsibilities to manage and report any safeguarding concerns via a first account report to the local authority. The Care Quality Commission had been notified about any safeguarding concerns by the registered manager as is legally required. The service had not developed an overview system of recording incidents of safeguarding and the outcomes of these any actions taken or lessons learned to ensure they had a clear overview.

The CQC had received no whistleblowing concerns since the last inspection. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. We spoke to staff about the principles of the whistleblowing policy and it was clear they had a good understanding of the policy and who they would notify if they had concerns. Staff also knew to be vigilant about the possibility of poor practice by their colleagues and knew how to use the home's whistleblowing policy. Staff told us they would be confident if they needed to report any concerns about poor practice taking place within the home.

Through discussion with staff and examination of records we received confirmation that there were satisfactory recruitment and selection procedures in place, which met the requirements of the current regulations.

We looked at a sample of three staff records for staff recently recruited. In all three files we found that there were application forms; references, medical statements; disclosure and barring service (DBS) checks and

proofs of identity including photographs. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service or their relatives if they found the service provided at Homeleigh to be effective. Comments received included: "I can't fault the staff they know me very well" and "I am happy here, the staff keep me focused."

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 refuse care and treatment when this is in their best interests and legally authorised under MCA. The authorisation procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. We discussed the requirements of the MCA 2005 and the associated DoLS with the locality manager. Discussion with the locality manager showed she had a clear understanding of the principles of the MCA and DoLS. At the time of our inspection nobody was under a DoLS. Although no DoLS authorisation were in place, we noted the garden area was not secure and could potentially result in people who lacked capacity and under a DoLS leaving the home. The locality manager acknowledged this observation, but confirmed the people living at Homeleigh were able to leave the home whenever they wanted and at this stage a secure garden was not required.

We found that staff had a good understanding of the requirements of the Mental Health Act 1983 (Amended 2007) and they made sure the MCA Code of Practice was followed. Staff were aware of the people who were subject to conditional discharges from sections and Community Treatment Orders (CTO). A CTO is part 17A of the Mental Health Act; this allows people to leave hospital and be treated safely in the community rather than hospital. A CTO means that people have to keep to certain conditions in the community, for example being compliant with their medicines.

We looked at the care files of two people subject to CTOs and found no evidence confirming they had been informed about the reason for their CTO and their rights under the MHA. People must be informed of their rights when restricted by a CTO. This meant that people's rights under the MHA were not fully protected to ensure they were being informed of their rights.

We also found that none of the people subject to CTOs had a specific CTO care plan in their files to tell staff what the conditions or restrictions were and how they should be supported to meet them.

Although support workers were aware of the people who were subject to a CTO, there was a potential staff were not clear on people's conditions or restrictions in place and how these influenced the support they required. This was a breach of Regulation 11 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had an induction when they started working in the home. New staff were required to undertake an induction process consisting of a mix of training, shadowing and observing more experienced staff. The induction process had been updated to include the Care Certificate.
This is a national qualification designed to give those working in the care sector a broad knowledge of good working practices.

Examination of training records confirmed that staff had completed key training in subjects such as: first aid; personal safety and breakaway; moving and handling; fire safety; food hygiene; safeguarding; medication; MHA, MCA & DoLS; infection control; and health and safety. One staff member commented, "The training on offer is very good; we have access to both e-learning and classroom training."

Daily handovers occurred between shifts to ensure important information concerning the needs of people using the service was shared. Staff also told us that they attended team meetings periodically and had access to an annual appraisal and regular supervisions with their line managers.

The most recent local authority food hygiene inspection for Homeleigh was in November 2016 and the home had been given a rating of 2 stars out of 5 (5 being the highest rating). We discussed this rating with the locality manager who felt the low rating was due to the home going through a number of refurbishments with the kitchen at the time being removed. The locality manager felt confident the home had made the necessary improvements and confirmed she would ask the Food Standard Agency to re-inspect.

Care plans recorded individual preferences and dislikes in respect of food and drink. People ate varied and healthy diets. People confirmed to us they cooked meals for themselves and others, thereby giving the opportunity to be independent. Care plans we saw emphasised that people would be supported to develop living skills such as cooking and doing their own laundry. People could also have access to an evening meal that staff made. Two options were served daily to provide people with a choice. Staff also told us how they promoted people's independence by supporting them to develop living skills such as budgeting. We received positive comments from people in relation to the support and food on offer: "The food on offer is very filling", "The meals are pretty good breakfast is a cooked breakfast, cereal or toast; we have a cooked meal at lunch and for tea", "The food is alright and I can cook whatever I like with support from staff" and "Staff provide assistance if I need a meal cooked."

We saw in people's care files that they had access to a wide range of healthcare professionals and facilities. People were supported to make healthcare appointments such as with their GP, the optician, podiatrists, hospital outpatients, dentists and their mental health team. Those requiring or requesting assistance to attend appointments were accompanied by a member of support staff.

Good

Is the service caring?

Our findings

We asked the people using the service if they thought the support staff were caring. People told us, "The staff go out of their way to help us as much as they can", "Staff are always caring, polite and respect my privacy" and "I have my good and bad days, but staff do care here."

During the inspection we observed staff supporting people at various times of the day and in various places throughout the home. Staff communicated in a kind and caring way and were patient and respectful. We observed staff being affectionate and tactile with people and this often helped to reassure people when they were unsettled.

Through our observations of staff interacting with people and from conversations with the staff, it was clear they knew the people they provided care for well. They understood people's preferences, likes and dislikes. They also had a good understanding of people's past lives, which enabled them to participate in meaningful conversations with people. This was confirmed by the relative we spoke to who also felt the staff knew their family member well.

On the second day of our inspection we observed one person becoming anxious and showing signs of aggression, a support worker was quickly on hand to reassure this person and redirected them to a different activity.

We saw people's privacy and dignity was promoted by staff during our inspection. The staff we spoke with described people using respectful language and this was also reflected in written records we saw, even when the people described had displayed behaviours that might challenge others, or other problems had occurred. People we spoke with said support staff always knocked on their bedroom doors if they wanted to speak with them and one person told us, "They [staff] are okay here; I think some are spies but I just got to get over that. I know they want me to succeed."

Our observations and people's feedback showed us staff promoted people's privacy and dignity.

During the inspection we saw people's confidential care files were kept in a lockable cabinet in the office to ensure confidentiality. Information on the service and of interest to people using the service was displayed on notice boards and in the reception area of the home for people to view.

Keyworkers had been established at the home ensuring people had a one-to-one session every month with their named keyworker, we found evidence of this happening. During one-to-one sessions people were asked how they were or if they had any issues or problems and the conversation was documented. A member of support staff told us if people raised issues that required a change in their care plan, then this would happen.

Advocacy services were available for people if they wished to access them. Posters promoting the benefits of advocacy were displayed in all of the communal areas, including lounges and in the main corridor on the

ground floor.

We asked the support workers about the people at Homeleigh. The staff members we spoke with could demonstrate how they made an effort to recognise people's diversity, including their gender, race, previous jobs, spiritual and religious beliefs, thoughts and opinions. It was clear to us from observing the support provided, all staff had developed caring yet professional relationships with each person as they knew people's life stories, interests and who was important to them in terms of friends and family.

Requires Improvement

Is the service responsive?

Our findings

People had an individual care plan which gave staff guidance and information they needed to support people. Each person had a communication passport. Care plans and communication passports were personalised; (a communication passport has information about how a person prefers to communicate). Care plans were in easy read formats so they were meaningful to people. Staff we spoke with knew about people's needs and the contents of care plans.

Support plans contained detailed information about people's health and social care needs as well as information about their likes and dislikes, preferences, hobbies and interests. Personal Daily Outcomes documents (PDOs) gave clear guidance to staff on how best to support people. Their daily routines were broken down and were clearly described so staff were able to support people to live their day to day lives in the way they wanted. Each activity was signed by staff when completed so they could ensure people had received the support they required. We checked the evaluations of care plans. We noted people were given a choice if they wanted to be involved in the evaluation of their care plans. We found evidence in the evaluations people were being encouraged and supported to become independent with a view to moving on from the home eventually.

People at the service because of their mental health needs had their care coordinated under the Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw written evidence CPA meetings took place with all relevant health and social care professionals in attendance. We saw outcomes of CPA meetings had been translated into current care planning records.

We spoke with a health professional prior to our inspection. This person confirmed they visited the home regularly to review the progress of their patients. Their comments included: "The service has not been reliable of late. I had one patient who has become unwell and the home never notified me of this. I feel the service could do more in the way of rehabilitation for people."

We viewed three care plans and found people did not have aspirational care plans which set out their goals and ambitions in terms of rehabilitation and recovery or what the next step was for their accommodation and personal independence. None of the care plans we saw included people's longer term plans or wishes; they were focused on meeting people's health needs in the here and now. One person we spoke with said, "I think the idea is for me to move one, but I am not sure."

By reading people's care files, speaking with people and making observations, we could see a proportion of the people at Homeleigh had issues with addiction, including cigarettes, alcohol and drugs. However, we could find no evidence in people's care files they were supported to rehabilitate or recover. There were no care plans focused upon health promotion and rehabilitation and no evidence that mental health tools such as the 'recovery star' were used. The recovery star is a tool which can be used to assess and track people's rehabilitation and recovery from various issues.

Likewise, we could find no evidence in people's care files they were being encouraged and supported to become independent with a view to moving on from the home eventually. We were informed by the locality manager that these discussions did happen, but had not always been recorded. One person told us people cooked in one of the communal kitchens as an activity and records showed people were supported to clean their rooms and manage their laundry, but apart from that, activities focusing on promoting people's independence were lacking. For example, we did not see evidence in three of the care files we looked at that people's ability to manage activities of daily living themselves, such as getting dressed, taking a shower or preparing their own meals was being regularly assessed.

On each of the floors there was a satellite kitchen which we were told people could access to make themselves drinks and snacks if they wanted to and to learn independent living skills such as cooking. A weekly cooking class had recently been established to support people with their cooking skills.

The services aims and objectives stated, "Supporting people to live a full and active life and promoting independence, which includes a full activity programme. Our new configuration provides a look and feel of supported living and enables individuals to develop their life skills to their individual potential. We utilise Personal Daily Outcome measures so everyone is continuously encouraged and supported to reach their full potential." We found this had not always been the case. When we asked what was in place for people wanting to move on, the locality manager confirmed the service needed to ensure people's aspirations were fully captured and acted upon. But commented the home had a clear model in place that provided people with their own flats within the home, which helped people understand what it is like living independent to a certain degree.

The fundamental purpose of Homeleigh was to support people to recover, rehabilitate and become independent. The lack of action to meet people's identified needs was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had recently made one of the support workers the activity lead at the home. We noted a number of trips out in the community had been arranged with some already taking place. The activities lead was passionate about this new role and had a number of ideas to ensure new activities were provided to people. Activities already in place included cooking classes (once a week), day trips out in the community, art sessions, pool and badminton tournaments, reading groups, attending football matches and the gardening club.

We found resident meetings were regularly held and we reviewed the minutes from the recent meetings. Within the minutes we saw people were consistently asked for their views about the operation of the service and where improvements could be made, such as around activities. Action was taken to incorporate people's views into the plans.

The home had a complaints policy and procedure and an effective system for reporting and responding to complaints and concerns was in place. The complaints policy included timescales for investigation and providing a response. Contact details for the service provider and the Commission were also included within the document.

We reviewed the complaints file. Records highlighted there had been four complaints in the last 12 months. Records viewed provided an overview of complaints received, action taken and outcomes. Copies of formal response letters were also available for reference. None of the people we spoke with at the home or their relatives said they had made a formal complaint. One person told us, "I am okay really; if I wasn't happy I would tell the staff or manager."

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who was previously the deputy manager. At the time of our inspection the registered manager was not available, due to leave of absence. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Comments received from staff were also positive about the registered manager. Staff said, "She [manager] is excellent, very approachable and hardworking", "If you have any issues the manager is always on hand to sort them out" and "I feel supported in my role; the management team are great."

During our inspection the locality and deputy manager were both present and engaged positively in the inspection process. We observed people approaching both managers directly and they communicated in a friendly and caring way. People were observed to refer to the managers by their first names which reinforced there was a friendly relationship between them.

We looked at the provider's systems for gaining assurance of the quality of service provided. The provider employed the services of an independent auditor to measure and review the quality of the service. Any concerns highlighted from these audits were addressed by the registered manager to drive improvement.

The registered manager also completed a monthly manager's audit. This audit looked at the following areas: care planning, key workers, activities, meetings, medication, environment, food menus, and training. The registered manager submitted a monthly quality report to the locality manager covering staffing levels, recruitment, eLearning, inductions and any other service concerns. The locality manager supported the registered manager to address any issues found and this was also used to measure and review the performance of the service.

Although audits had been undertaken in relation to the environment and people's care, they had not been particularly effective in resolving the concerns found during the inspection in relation to the medicines, risk assessments, environment and identifying people's future aspirations.
Not ensuring the service had an effective quality monitoring system was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staff we spoke with confirmed that they had attended monthly team meetings. We viewed the meeting minutes for January, February, March and April 2017, and found these had been well attended by staff.

We noted systems were in place to seek feedback from people using the service. Surveys were sent to people every six months. Surveys had recently been distributed in 2017. The majority of feedback was positive. The provider had put together a graph detailing the results.

The management team understood their responsibilities with the Care Quality Commission and had

reported significant information and events, such as notifications of deaths, serious injuries and any safeguarding issues.

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 There was a lack of comprehensive care and support planning and action to meet people's future aspirations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not always act in accordance with the Mental Health Act 1983.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected by safe administration of medicines. And People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate the risks.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Although audits had been undertaken in relation to the environment and people's care, they had not been particularly effective in resolving the concerns found during the inspection in relation to the medicines, risk assessments, environment and identifying people's future aspirations.

The enforcement action we took:

Warning notice