Lovestar Limited

Homeleigh Residential Care Home

Inspection report

The Bungalow
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London
SE18 3NR

Tel: 02083314343

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08 July 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Homeleigh Residential Care Home is a small care home that provides accommodation and personal care support for up to five adults with learning disabilities and or autism and who may have enduring mental ill-health. At the time of our inspection four people were using the service.

People's experience of using this service and what we found
Risks to people's physical health and safety were not always identified and with appropriate actions put in place to mitigate such risks.

The registered manager continues to fail to put systems and processes in place to assess, monitor and improve the quality of the service. Records of incidents and care people received was not always maintained.

People were supported to integrate in the home and social inclusion was promoted. The registered manager understood their responsibilities to safeguard people from abuse and had followed the provider's safeguarding policies and procedures to address any safeguarding concern raised.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Records showed consent was obtained from people and their representative for the care and support they received, where appropriate. Records showed people's legal rights were protected in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was Inadequate (published 31 December 2019) as there were breaches of regulations 9, 11, 12, 13, 16 and 17 and Warning Notices were issued for breaches of 11, 13, 17. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulation 11, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns.

They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Homeleigh Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service.
Inspection team
This inspection was carried out by two inspectors. One inspector visited the home and the other inspector supported the inspection remotely.

Service and service type
Homeleigh Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection site visit took place on 8 July 2020. We notified the service of our inspection on the morning of our inspection because we needed to give the registered manager time to arrange for suitable space for us to work from to enable social distancing rules to be followed.

What we did before the inspection
We reviewed information we had about the service since the last inspection. This included reviewing the provider's action plan we had asked for following our last inspection and notifications we had received about the service. We used all this information to plan our inspection.

During the inspection
On the day of our inspection we spoke with the registered manager, deputy manager and two support workers. We reviewed four people's care plans, staff training matrix, health and safety records, incident and accident records; and other records relating to the management of the service. We spent some time observing staff interactions with people.

After our inspection, we spoke with two relatives to seek their feedback about the service.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. This meant people were not safe and were at risk of avoidable harm.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served on the breach of regulation 13. We will assess all of the key question at the next comprehensive inspection of the service to provide a rating.

Systems and processes to safeguard people from the risk of abuse
At our last inspection we found the provider had failed to ensure people were safeguarded from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the registered manager had procedures in place and followed practices that promoted people's rights and safeguarded them from abuse. The breach of Regulation 13 had been met.

● The registered manager understood their responsibilities to safeguard people in their care from abuse. They notified us of a recent safeguarding allegation and had carried out an investigation into the allegation and had followed the relevant procedure.
● People's right to integration and inclusion was promoted. One person who was at risk of segregation in the annex of the home was supported to spend time with others in the main building.
● Staff understood how to promote people's freedom and choices. There was no evidence that people were restricted. We observed that one person went out and returned to the service without any restrictions and as they wished.

Assessing risk, safety monitoring and management
At our last inspection there was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to robustly assess the risks relating to the health, safety and welfare of people.

At this inspection we found some improvements had been made but further improvements were needed to ensure risks to people were managed effectively.
● Risks to people were not always identified and comprehensive plans developed to ensure people were protected from avoidable harm.
●There was no appropriate guidance in place for staff to follow to recognise signs of high or low blood sugar for one person who was diabetic. Therefore, this put the person's physical health at risk. After our inspection,

the registered manager sent us a risk management plan covering this. The management plan was detailed and provided guidance for staff to support the person to maintain their physical health.

● There was no risk assessment in place to ensure one person remained safe whilst accessing the local community or to address the risk of them going missing. There was no guidance in place for staff to follow if the person failed to return to service or went missing. After our inspection, the registered manager sent us a risk assessment and care plan to manage their safety in the community, highlighting actions for staff to follow in the event of the risk of the person going missing.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served on breach of regulation 11. We will assess all of the key question at the next comprehensive inspection of the service and to provide a rating.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to work within the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards which meant that people's rights were not upheld or protected. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found that the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were followed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Where required, a mental capacity assessment had been completed for people. In areaswhere people lacked capacity to make specific decisions for themselves, Best Interest decisions were made, involving the person where appropriate and their relevant representatives, to ensure their needs were safely met.
- Where people had capacity to make decisions for themselves, we saw signed consent forms from people on specific aspects of their care.
- There were valid DoLS authorisations in place and their conditions were met.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served on breach of regulation 17. We will assess all of the key question at the next comprehensive inspection of the service.

Continuous learning and improving care
At our last inspection we found the provider had breached regulation 17 for failing to operate systems to assess and monitor the quality of the service.

At this inspection we found further concerns with systems for monitoring the quality and safety of the service and the provider remained in breach of Regulation 17. This was therefore the third inspection in which we found a continued breach of regulation 17.

● We found that care records were not always audited to ensure they were accurate and reflected the care and support people required. We found concerns in three of the care records we checked. Information in the care records were not always robust and did not always cover people's physical health needs. In one person's moving and handling risk management plan, the number of staff needed for safe transfer was not included. We checked with the registered manager and found this had been omitted in error. This error had not been picked up before our inspection because care records were not always audited.
● We found staff did not always record all concerns they had about people and any support they had provided. We noted staff had recorded in one personal's behavioural chart a comment a person had made which was of concern and would require monitoring so that appropriate support could be given to the person. The registered manager and a care worker both told us that the person had made similar comments of concern prior to the one recorded in their behavioural chart on 21 April. However, no other record was found about this person making this comment previously; neither in incident logs nor daily logs. This showed that records were not always accurately maintained relating to incidents and care and support people received. The registered manager had not identified this through quality monitoring process.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always identified and comprehensive plans developed to ensure people were protected from avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality of the service was not effectively assessed and monitored to identify pitfalls in the service