Hudson (Haven Lodge) Limited

Haven Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on the 8 August 2018 and was unannounced.

At our comprehensive inspection of this service in November 2016 seven breaches of legal requirements were found. The provider was not following the Mental Capacity Act 2005, people were not having their care provided in a dignified or respectful way. People were receiving unsafe care and treatment and were at risk due to inadequate care relating to their nutrition and hydration. The provider had inadequate systems in place that identified shortfalls and records were incomplete. Staff were not receiving training, supervisions or had the skills and knowledge to support people within the service. There were also inadequate checks undertaken on new staff prior to them starting employment at the service.
Following this inspection, we placed the provider on notice of urgent action and we put the service into special measures. This is when the provider is responsible for the care it provides and for improving quality and safety in response to our judgements and ratings. When a service is in special measures we expect the provider to seek out appropriate support to improve the service from its own resources and from other relevant organisations. The provider also wrote to us to say what they would do to meet legal requirements in relation to these breaches.

The service was inspected in February 2017. After this inspection we used our enforcement powers and served a Warning notice on the provider, in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in April 2017, as the provider's quality assurance systems were not in place or effective at identifying shortfalls relating to infection control, personal evacuation plans and medicines management. Some audits had been undertaken during and following our inspection those shortfalls were yet to be actioned This is a formal notice which confirmed the provider had to meet one legal requirement by May 2017 .

We undertook a comprehensive inspection in July 2017. This was to follow up our warning notice issued and previous breaches of legal requirements. At this inspection whilst there were some improvements there were still concerns relating to previous breaches including records that were inaccurate and incomplete and shortfalls in staffing numbers, staff receiving training, supervision and a regular appraisal of their performance yearly appraisal. The service was rated as Requires Improvement.

We undertook an unannounced focused inspection of Haven Lodge Care Centre on 22 February 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection had been made. We had received information that the management arrangements in the service were not consistent. This focused inspection looked at the breach of regulations 12, Safe Care and Treatment, 17, Good Governance and 18 , Staffing. At this inspection, we found the provider had taken action to comply with some of the legal requirements. However, further improvements were still required regarding the recording of medicines, support plans and effectiveness of quality assurance systems. We found continued breaches of Regulations 12 and 17.

You can read the reports from our last inspections, by selecting the 'All reports' link for Haven Lodge Care Centre, on our website at www.cqc.org.uk. The service remains rated as requires improvement.

Haven Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement . The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Haven Lodge Care Centre is a registered nursing home and can accommodate 106 people. At the time of the inspection there were 27 people living at the service. The accommodation at the time of the inspection was arranged over two floors. The first floor is Willow and the second Sycamore. Each floor could have up to 27 people living on them. The third and fourth floors were not being used at the time of the inspection. Both Willow and Sycamore floors had a communal lounge, dining area, bathrooms and toilets.

Since the last inspection in February 2018 the previous registered manager had left the service. At the time of our inspection the manager was not registered with CQC. The manager had been in post for two months, and was the third manager in four months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have 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 last inspection in February 2018, the service was rated, 'Requires Improvement'. We found breaches in Regulation 12 and Regulation 17. Some protocols for the use of 'when required' (PRN) medicines were missing in care files. Quality checks on the service were not robust enough and lessons learnt not passed on to staff to improve the service. We asked the provider to take action to make improvements to medicines and quality monitoring. At this inspection we found there had been no improvements and the issues remained regarding the review of these and in the management of quality checks. This is the second time the service has been rated 'Inadequate'. We found there remained breaches of Regulation 17 and 12. In addition we found four other breaches.

Medicines were not managed consistently safely. Where people received their medicines without their knowledge (covertly) the provider had not followed best practice guidelines.

The issues associated with Regulation 11 we had found in our last comprehensive inspection in July 2017, had been addressed but a new breach of Regulation 9 (Person centred care) of the Health and Social Care Act was identified with regards to the ongoing review of people's care to ensure it remained appropriate to their needs and preferences.

We looked at six care plans and found some improvements to the information relating to people's needs and wishes had been made but other information was poor. Some of the information relating to people's level of risk was contradictory, some of the risk management advice stated was inadequate and some people's risk management plans were not followed. This meant that there was a risk that people's health and welfare were not being managed properly.

Improvements were needed to the way people's ability to make decisions about their care had been assessed and the way people's legal consent was obtained in line with the Mental Capacity Act 2005.

People had access to a limited range of social or recreational activities in support of their emotional well-being.

People and the relatives told us that there were not enough staff on duty to meet their needs.

Staff supervisions and staff appraisals were not up to date. Nursing staff had not received clinical supervision for some time.

The provider had audits in place to check the quality of the service but these were ineffective. Improvements to the care planning and the delivery of care identified at the last inspection had not been sustained through good management and some aspects of service delivery had declined in terms of quality and safety.

The audit and governance systems in place failed to pick up and address the issues found at this inspection.

Managerial and provider oversight was insufficient and by consequence the ability to mitigate risks to the health, safety and welfare of people who lived at the home was seriously compromised. This service was not well-led. The provider had failed to inform us about one incidents.

People on Willow floor told us that staff were kind, however on Sycamore floor, staff found it difficult to care for people as they would like to due to lack of staff.

Staff had been recruited safely.

Staff interacted with people well and were kind and considerate in most of their support interactions.

People who required special diets were provided with the diet they needed and people's food and drink charts were completed appropriately.

The environment was clean and safe but there was a noticeable odour on Willow floor. The home's gas, electric and moving and handling equipment had all been certified as safe to use .

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to: - Ensure that providers found to be providing inadequate care significantly improve. - Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Arrangements were not in place to ensure medicines were effective when given without people's knowledge (covertly).

Formal arrangements were not in place to ensure people received prescribed supplements correctly.

Some protocols for the use of 'when required' (PRN) medicines were missing in care files and others were not individualised.

Risk assessments were completed however plans to mitigate the risk were not consistently in place.

There were not sufficient staff available to meet people's needs.

People lived in a home that was clean and attractively decorated

Is the service effective?

Inadequate

The service was not effective.

Staff were not up to date with the necessary training for their roles and for nurses, this linked to reviews of clinical competency.

Staff were not supported by regular supervisions or appraisals.

Staff assessed people's mental capacity, with best interests' decisions documented. However, we found inconsistent recording of consultation with relatives and healthcare professionals.

Value was placed on the importance of people having choice of food and drink to meet their nutrition and hydration needs was mixed.

Is the service caring?

Requires Improvement

The service was not always caring

The care and support people received was not consistent across the service.

Whilst people and relatives told us staff were kind and caring, there was limited information in care files about people's involvement in care decisions.

Staff treated people with kindness and gentleness.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People did not have detailed and personal care assessments and reviews of their care.

There were limited activities taking place.

The service was not linking people's interests and experiences with the activities on offer.

People's needs were not always met in a personal way which put them first.

Is the service well-led?

Inadequate

The service was not well-led.

People, relatives and staff had not been involved in the running of the service.

The provider had not identified through their own systems and checks that people had been receiving poor quality care.

The lack of effective checks put people at risk of unsafe care and treatment and potential risk of harm.

The provider was not always keeping us informed of required incidents.

Haven Lodge Care Centre

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 took place on 8 August 2018 and was unannounced. The inspection was carried out by two adult social care inspectors, one pharmacy inspector and an expert by experience. Our expert by experience had knowledge and understanding of residential services or caring for someone who uses this type of care services.

We did not ask the provider to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

Some people at the service were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

At this inspection we spoke with eight people who lived at the home, two relatives, the new manager, the manager for Willow floor, one nurse, four care staff, the maintenance person and the head of housekeeping. We examined a range of documentation including the care files belonging to six people who lived at the service, nine staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the service and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

At our previous inspections, in November 2016, February 2017 and February 2018 we found that medicines were not always managed safely. In November 2016, July 2017 and February 2018, we found people's risk assessments were not always updated or contained enough information for people to be kept safe. In November 2016, February 2017 and July 2017, we found there were not enough staff to safely support people. However, at our inspection in February 2018, we found that there had been a significant improvement. At the focused inspection in July 2017, we found some, but not all the required improvements had been made. We asked the provider to send us action plans monthly stating how they were going to meet the legal requirements.

At our last inspection, we identified a continued breach of Regulation 12 which related to safe care and treatment at the service for the people who lived there.

During our inspection we looked at the systems in place to manage medicines. Medicines were administered by nurses and senior care workers. Staff used medication administration records (MARs) to record when a medicine had been given. We reviewed 11 MARs and found they had been completed. However, we found some medicines were not being administered as directed by the prescriber. Handwritten additions to MARs had been dated, signed and double checked by a second member of staff. The time taken to complete the medicines round on Sycamore Floor, the nursing floor, appeared very long as the breakfast medicines were still being administered at 10:45. Some of the medicines were time specific, such as medicines for Parkinson's Disease. The actual time these medicines were given was not recorded, so we were unable to see whether they were given on time or if there were suitable gaps between the administration of medicines. We then noted that just as the breakfast medicines had been given, lunch time medicines were being prepared.

People who were prescribed patches containing medicine, had separate recording charts which had been appropriately completed. Where people had creams applied by trained care staff we saw there were body maps to instruct them where to apply these creams. Records of administration were completed. Topical creams and lotions in people's bedrooms had labels on to inform staff when they were due to expire. However, we saw creams in three people's bedrooms that had expired and staff had not disposed of them. Additionally, we saw a cream in one person's bedroom that had a dispensing label on for a different person.

We looked at the care plans and records of two people who had thickeners prescribed following a Speech and Language Therapist assessment. This is a powder that thickens food and drink for people with swallowing difficulties. The information available to care staff for one person did not reflect the product that had been prescribed for them. A staff member was unclear how to use the product currently in use.

Suitable records had been kept for the ordering and disposal of medicines. However, the checking of medicines on receipt was not effective. We found that eye drops for one person had not been received and no action was taken to source a replacement until after the first dose was missed .

Medicines that required more security were stored securely. Medicines were stored in conditions as advised by the manufacturers. Fridge and room temperatures were being recorded daily. Records showed that the temperatures were within the range specified by the medicine manufacturers. Opening dates were being recorded on most liquids and eye drops. There were some sterile products kept in the medicines room which had been opened and not disposed of. This could lead to products being used inappropriately.

Staff had some additional information protocols for most medicines prescribed to be taken 'when required' and they explained when medicines could be given. There were no details of assessments that needed to be made prior to administering the medicines and when the medicine should be administered and what the outcome should be. Some protocols were missing from care records on the day of inspection, this meant staff may not give doses of medicines as intended by the prescriber.

Some people were receiving covert medicines (medicines given without their knowledge). Some records showed that people's mental capacity had been assessed and their best interests had been considered with a GP and family members and pharmaceutical advice had been sought. However, this was not consistent and some did not.

Care plans contained risk assessments for areas such as mobility, falls, skin integrity and malnutrition. When risks were identified, the plans provided some guidance for staff on how to reduce the risks to people. For example, when staff needed to use equipment to move people safely, this was documented. When people could move around with mobility aids, it was documented when staff needed to supervise people or if they could do so independently.

Some people had been assessed as being at risk of falling from bed. In these cases, bed rails risk assessments had been completed although the quality of information was poor. For example, in one risk assessment it had been written, "Staff who know [person's name] well, feel [they] are at risk of falling out of bed." The provider's written guidance stated the minimum height that should be present between the top of the mattress and the top of the rails was, 'Greater than 220 millimetres', to prevent people at risk of falling out of bed hurting themselves. However, we saw two risk assessments where staff had written the distance was less than 220 millimetres. We checked four people's bed rails and saw that three people had rails in place where the distance between the mattress and top of rail was less than the provider's guidance. This meant there was a risk that people could roll over the top of the bedrails because the overlay mattresses in use reduced their effective height. Staff who had completed the risk assessments had not identified the risks to people.

We looked at the plan for another person with bed rails. On 01 June 2018 it was written, "Staff to check on [person's name] at all times as tends at times to climb over the bedrails." This meant that bedrails were unsuitable for this person because the risk of harm from them climbing over the rails was known to staff. Of the assessments in place none detailed what, if any, less restrictive options had been considered to keep people safe.

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

There was not enough staff on duty to meet people's needs. One relative said, "I don't think there are enough staff." On Sycamore unit we saw most people needed two members of staff to assist them with personal care. During the morning, two staff members were assisting people in their rooms whilst another staff member was making breakfast and assisting those who needed support to eat and drink. This meant that some people were eating breakfast at 10.40 hours. We saw two people waiting for their breakfast in the

dining room. Both needed staff support. One person was supported at a time, which meant the other person had to watch and wait for their breakfast.

All staff we spoke with said staffing levels were inadequate. One said, "Staffing levels are terrible. It's not safe." Another said, "It's so unsafe. We've all raised it with [the provider] many times." The staff said the levels impacted on their ability to provide person centred care. Comments included, "We can't give person centred care. If four people want a shower, we can't do it" and "Staff must rush. It's like a conveyor belt." One member of staff said, "I've had to ask a cleaner to keep an eye on someone because I was so desperate to go to the toilet and there was no-one around to relieve me." Another said, "It's common for us [staff] to cut short our breaks so that we can get back and help to change people's positions on time." One member of staff said, "I've had to eat my lunch sitting with someone who was dying because there wasn't anyone to relieve me."

We saw that a member of staff from Willow unit went to help staff on Sycamore unit. They said, "We always help out. It's not fair that they have to struggle." We spoke with the manager about this and they told us that the provider had stipulated that according to the dependency tool they used, only three carer staff were needed on that floor. However, we saw that most people needed two staff for all their personal care needs. The manager acknowledged that they needed another member of staff and that was why staff from Willow floor went to support colleagues and the administrator had to fill in the gap left. The provider used agency staff to cover shifts whilst they recruited permanent care staff and there was no clinical lead to support and direct the nurses. The service had two permanent nurses. One nurse covered five nights and the other covered three days shifts, therefore agency nurses were covering six 12 hour shifts a week.

There were not enough staff available to meet people's social and recreational needs. On Sycamore floor, several people were being nursed in bed. We saw that aside from when care and support was being provided, they had very little social interaction. There was no activities provision for people as there was no dedicated activity co-ordinator for this floor and all the activities were based on Willow floor. One staff member said, "I try to do one to one's with people. But we're so short staffed I'm constantly saying in a minute." Another staff member said, "[Person's name] likes to go out in the wheelchair, but there's nobody to take them."

The manager acknowledged the staffing levels were unsafe on Sycamore . They told us they filled in a dependency tool every week and sent it to the provider who then calculated the number of care hours and care staff were needed to care for the people who lived at Haven Lodge. The manager also acknowledged that the day following the inspection, at least half the care staff would be agency staff, as would the nurse , It was unclear what the staff skill mix would be plus this meant there was a lack of consistency for people as they would be cared for by staff who possibly did not know them.

Relatives told us that staff did try and chat with their relatives. One relative told us, "There is a high staff turnover, she [Mum] gets to know them then they go again, or they move upstairs which is a shame." However, we observed that staff, especially on Sycamore floor did not have time to chat and spend time with people as part of their working day.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe living at the service and relatives told us their relatives were settled. Comments included, "I feel safe there's always someone around," Yes I feel safe here" and "I think she is safe and well looked after, she has had some falls which I don't think could've been avoided really." Staff were trained to

keep people safe from avoidable harm. They were aware of their responsibilities to report any concerns to the manager or outside agencies as appropriate.

Staff were safely recruited using the providers recruitment processes. Staff had completed an application form, attended an interview, supplied references and had been checked externally by the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable people. The provider was striving to maintain a permanent staff team with ongoing recruitment. One staff member commented, "There's high staff turnover, some start and can't handle it."

Accidents and incidents were recorded in line with the provider's policies and procedures and analysed for trends, so action could be taken if they were found

The premises were clean and tidy, however there was a strong odour on Willow floor and the manager told us they were going to replace the carpet in the near future as it was "Quite embarrassing but they were having the carpet cleaned as often as they could". One relative told us, "The place is clean and the staff do their best." The chef told us they had already completed a deep clean of the kitchen area. Domestic staff were on duty and we saw they had designated responsibility for specific areas of the service. We observed staff followed best practice guidance in relation to the control of infection such as the use of colour coded equipment and degradable bags for soiled laundry. All staff were observed using personal protective equipment as necessary to prevent cross contamination.

Risk assessments were completed and regular checking and servicing of fire safety equipment. Such as fire doors, emergency lighting and extinguishers. regular fire drills took place. Staff confirmed that fire drills had taken place, one said, "Fire drills do happen."

Inadequate

Is the service effective?

Our findings

At our inspection in November 2016, we identified repeated breaches of Regulations 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not always receive the sufficient level of support to eat or have sufficient fluids, the service did not fully adhere to the Mental Capacity Act 2005 (MCA) in relation to people's rights to provide consent to care and treatment and staff did not have sufficient or appropriate training to carry out their roles.

At our inspection in July 2017, we found some improvements had been made but areas were still needing improvement. Therefore, the effective domain was rated as requires improvement. At our focused inspection in February 2018, we found that sufficient improvements had been made, resulting in the effective domain being rated as good.

The provider held a training matrix listing their mandatory training requirements. From reviewing training data, completion rates varied, particularly with training areas such as medicines management, safeguarding adults, dementia awareness, infection control and mental capacity assessment. We could not be assured that staff had all necessary training and skills required to fulfil the requirements of their job role.

Staff said they had received some training to carry out their roles although feedback about the quality of training was mixed. One said, "I started a dementia course, but then it just fizzled out. Not sure what happened." Another said, "I wanted to do dementia awareness, but I couldn't leave the floor because we were short staffed." One said, "A lot of it is videos to watch." Another said, "We were asked a while ago by the last manager to identify our training needs. But then she left, so I don't know what's happening about it." Nurses told us they felt that the lack of a clinical lead did not support them with the revalidation process, linked to the maintenance of their registration with the Nursing and Midwifery Council.

None of the staff had an up to date regular performance appraisal in place, although the manager identified that dates for later in the year were planned. Staff performance was not regularly reviewed or robustly monitored, particularly in relation to nursing staff competencies. Staff told us and it was acknowledged by the manager that staff had not received regular supervision for some time . Staff told us that they had not had supervision for at least six months. Supervision is where staff meet one to one with their line manager to discuss their performance and development. The provider's policy stated that staff were to have supervision at least every eight weeks. The manager thought it was every three to six months.

Staff said they had group supervision sessions. Staff told that these were not always constructive. One staff member said, "Group supervisions only tend to happen when something isn't right, or you forget to do something. They're not an opportunity to discuss how work is going." Several staff told us they had a group supervision session recently. They said, "We had a group supervision a while ago and were told we were having a pay rise, but we all had to work harder in order to get it. They [management] said all paperwork must be filled in, we must turn up on time and not go off sick." This meant that the provider was not individually reviewing or supporting staff performance and development.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found people's nutritional needs were assessed and people's weights were monitored. However, when people lost weight, the actions taken had not always been documented. For example, one person had lost 6.4 kgs in six weeks. A member of staff had noted the weight loss and had documented when they had contacted the GP to advise them of the person's, "Poor intake." We asked what action was being taken and were told the GP had been contacted again the day prior to our inspection. This was not written in the care plan, but in the diary staff had ticked to indicate they had spoken to the GP and written, "GP said to push fluids." This did not detail the conversation held with the GP and did not demonstrate the GP had been informed of the amount of weight lost. A staff member said they would contact the GP again. We discussed this with staff, who were unaware of the person's weight loss or of their food preferences as stated in their care plan.

Other plans we looked at showed that people were referred for specialist dietary advice when required. We saw records of dietician reviews and their advice had been incorporated into the care plans. When people had difficulties swallowing speech and language therapist were contacted for advice about thickened fluids and textured diets. The brand of thickener in use had changed formula and the guidance for staff was not clear in relation to whether the thickener in use was the old or new formula.

On Sycamore unit we saw one person being supported with their meal in the lounge, from a staff member who was not part of the care team. The staff member did not interact in any way, did not tell the person what the food was or ask if they were enjoying it. One member of staff said, "That's normal for them to help. It helps us out. We don't ask [staff member's name] to support anybody who's at risk of choking." However, this did not lead to a sociable meal experience for the person being supported. We also noted most people living on Sycamore needed staff support to eat their meals and because of the low number of staff people were still eating their breakfast at 11.30am as staff were assisting with meals and trying to provide personal care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent to care was not always sought in line with legislation. People's capacity to consent to aspects of their care had not always been assessed. For example, some of the assessment forms we saw had been pre-populated which meant people had not always been assessed individually. In one person's care plan it had been documented that a relative had been rung to ask about power of attorney but the outcome of the discussion had not been recorded. We saw a capacity assessment for one person to assess their ability to consent to living at the service. Staff had written, "Due to the effects of progressed dementia", but records showed the person did not have a formal diagnosis of dementia. Some of the mental capacity assessments had not been signed or dated by staff.

One person had been assessed as being a high risk of falls. The plan guided staff to walk with the person holding their hands when mobilising. We saw the person sitting in a recliner chair with their legs and feet elevated. Staff said because there wasn't enough staff to be with them all the time, this was to prevent the person standing up unsupervised and it therefore reduced the risk of them falling and hurting themselves. Staff told us that this person had fallen in the past and they were trying to keep him safe. However, there was no mental capacity assessment or best interest decision for this to happen. This demonstrated that staff did not understand the principles of the Mental Capacity Act .

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff files showed that new staff completed an induction programme including spending time with experienced staff shadowing shifts and completing a corporate induction programme. However, we found one staff that had not worked in a health and social care setting previously had not been placed on the Care Certificate, which meant that staff may not be aware of best practice guidelines and potentially put people at risk. The Care Certificate is a modular induction which introduces new starters in health and social care to a set of minimum working standards. The manager confirmed this was the case, for one staff member who had been working at Haven Lodge Care Centre for over six months.

Some people were having their food and fluid intake monitored. Target intakes were written on charts and in the main people had exceeded these. Food monitoring charts had been completed in full. Records showed that food and fluid intake monitoring was robust, because staff had documented when people's intake had been poor.

We observed lunch on Willow unit. Several people were sat in the dining room, the tables were laid and people had access to drinks. People were offered a choice of main meal and staff asked, "How many potatoes would you like?" and "Do you want gravy on this?" Staff asked if people were enjoying the food and people responded positively.

The chef worked with staff to manage people's nutritional needs, including adding supplements and increased calories to people's diets. We also saw snacks were available in the two lounges, however in Sycamore Lounge, we noted that for some time the snacks were just an empty packet of crisps and a bag with an apple core in it. These had been left by night staff, we were told, and weren't removed until lunch time and replaced with new snacks.

People had access to ongoing health care. The GP came to the service requested by staff. Records showed people were reviewed by the dietician, SALT and specialist nurses .

The home had undergone a complete redecoration. On Willow floor it was decorated especially for people living with dementia, with things such as hats and bags that could be moved around and tactile areas. We observed people moving around and making use of their environment.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in July 2017 we rated the provider as 'good' under the key question of 'Is the service caring?'

At this inspection we found that aspects of the service impacted on the quality of care some people received. The manager agreed that staff were struggling to provide the quality care they wished to on Sycamore floor due to being, "Short by one staff member" and the high use of agency carer staff and nurses who did not always know people as well as the permanent staff.

On Sycamore floor , whilst we found people were being supported to eat and drink there was little verbal interaction with people. We observed staff entering Sycamore lounge, assisting one person with a drink and there was little interaction with the staff member saying, "Here we go, here's a drink for you," before leaving. Later in the day, we again observed staff, whilst not rushing people, having little interaction with them whilst providing care .

Other staff said, "I do think people downstairs [Willow] get good care" and "I don't think the staffing levels impact on the quality of care, but it does impact on our paperwork." Others said, "It's not by choice, but we can only do task focussed care. It's because of staff shortages."

At this inspection people and relatives told us about the staff, their comments included: "Staff are caring, I feel listened to and I am left to do what I want to do. Care staff are caring and friendly." and "I think the care is exceptional, everyone is very good with Mum: they have a lot of patience and value her." However, we found there were clear differences between the care and support people received on Sycamore and Willow floor.

We observed positive interactions between people and staff on Willow unit . Staff called people by their first names and people responded positively. People were smiling with staff. We saw that staff genuinely cared for people and treated them with respect and compassion. Staff were friendly and patient when offering or providing support to people. We observed a member of staff transferring a person from a chair to a wheelchair. Two staff assisted the person. One staff told the person what was going to happen and asked if that was okay and were they ready. Once staff had established they were, each movement was spoken through. Both staff gave assurance in a calm and comforting tone.

Staff spoke highly of their roles. Despite the challenges in relation to staffing levels, all staff said they stayed because of, "The residents." One staff member said, "The residents keep me here. I love it here. I worry about the negative impact on them if I left." Another said, "I do feel people get good care here, but it's rushed and that's not what we [the staff] want. This is meant to be their home."

Staff knew how to treat people with dignity and respect. We saw that staff knocked on doors before entering people's bedrooms. One member of staff said, "I'm very discreet. If someone needs personal care, I will whisper to them to come to their room with me." We saw two members of staff say to one person, "Shall we

go and change your trousers, and give you a freshen up?".

We saw staff offering people choices throughout the inspection. For example, we saw one member of staff say to one person, "Shall we go down to breakfast? What do you fancy? [Cereal name] again or something different?" Another member of staff took one person into the lounge and asked, "Would you like the TV on?" The person said they would and the staff member said, "Which channel would you like?". Staff told us, "We offer a choice at lunch" and "I will hold two outfits up for people so they can choose what to wear." One said, "Despite being short staffed, we still offer people the choice of getting up or staying in bed."

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection in November 2016, we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people who remained in their rooms were at risk of social isolation due to the lack of activities.

At our inspection in July 2017, we found improvements had been made to activity provision and the service was now responsive to people's needs. People had one to one time, an activities timetable demonstrated the provision for people and there were opportunities to access the local community

People's comments about activities at this inspection included, "It is the same thing every day really, sometimes we play skittles and bingo. Someone came in with a dog once, though it was a while ago I might have dreamt it," "I am so bored, I have decided to eat these crisps to pass the time of day. Nothing much ever happens here, but it is to be expected at my age," and "I'm not sure whether I can really go out when I want to, I do like walking though I am in here [in the lounge] most of the time. I am really sick of the TV and I am bored of sitting around. I have drunk more tea here than I have ever done in my life."

At this inspection on Willow floor, we observed the activities co-ordinator telling people that they were now going to play a game of bingo. People had not been asked if they wanted to play but they appeared happy to do so as they put down the newspapers they were reading. Once bingo had been set up another staff member came to support one person to join in. This made the game accessible to this person. However, this support was cut short as the staff member was asked to go to Sycamore floor to support colleagues. Near the end of the game, one person was brought down from Sycamore floor to join the activity, however, they were unable to take part as they needed one to one support, and ended up sitting in an armchair doing no activity. This person had been heard by a member of the inspection team telling staff that they did not want to come down to Willow floor to play bingo as they didn't like it. We spoke with the manager about this and they confirmed that the person did not like to play bingo and the staff should know that too. This meant that this person's views and choices were not being listened to or met.

On Sycamore floor, several people were being nursed in bed. We saw that aside from when care and support was being provided, they had very little social interaction. There was no activities provision for people as there was no dedicated activity co-ordinator for this floor and all the activities were based on Willow floor. One staff member said, "I try to do one to one's with people. But we're so short staffed I'm constantly saying in a minute." Another staff member said, "[Person's name] likes to go out in the wheelchair, but there's nobody to take them."

People and their relatives told us that they had not contributed to their care plans or reviews. One person said, "No, I don't think I have been involved in talking about my care and support, not since I came in here." A relative said, "No, I have never been invited to have a review of my Mum's Care Plan."

Care plans for people did not always provide enough information for staff. For example, when people were at risk of developing pressure ulcers, although equipment in use, such as air mattresses was documented,

the correct setting for the mattress was not recorded. When people needed their positions changed regularly because of the risk of pressure ulcers, the required frequency was not written in the plans. Despite this, positional change charts did state the required frequency and we saw that people did have their positions regularly changed. All the air mattresses we looked at were set correctly.

Care plans provided basic information about people's needs but were not consistently person centred and did not always detail people's choices and preferences. Although we saw some good examples, such as, one person's sleep plan which read, "Likes curtains drawn, bathroom light on, handbag on the bed and TV LED light off," this was not always the case. For example, personal hygiene plans did not always indicate if people preferred male or female staff to support them. The plans for gentlemen did not state if they preferred a wet or dry shave. In one person's hygiene plan it was written they liked to, "Look nice" but there was no explanation of what this meant. This meant that people may not receive care in their preferred way which is especially relevant in care plans where there is a high use of agency staff. Staff were monitoring interactions between one person and others living at the service. There had been some incidents of verbal and physical aggression which staff had reported. However, there was no plan in place to inform staff how to support the person during these occurrences or how to keep themselves and other people safe. We asked a member of staff who said a plan had been written, but they were unable to provide it for us . This meant that staff may not be aware of effective strategies to support people and keep them safe.

We looked at the wound care plan for one person. The plan was clear and staff had documented the wound dimensions and recorded when photographs had been taken. However, the latest photograph within the plan was dated 27 April 2018. A member of staff said the pictures were on the camera and had not been downloaded yet. This meant it would not be easy for staff to monitor if the wound was improving or deteriorating .

We were told that there was one person who was on end of life care. This was a letter in their care plan from the hospital stating that most of their medicines had been stopped and "just in case" medicines had been given to the service. These medicines to help relieve pain or other symptoms if needed, especially during the night or at the weekend. We looked to see if there was an end of life plan for this person. We could not find any. We looked to see if other people had end of life plans in place. We found there were none in the care plans we looked at . These are plans that detail people's choices about the care they want at the end of their lives. We fed this back to the manager, and they agreed that these were not in place .

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had social and mental well-being plans in place which gave some information for staff on what people liked to do. For example, in one plan it was written the person liked to sing, play the piano, listen to music and read. However, people's choices were not written in detail, such as the type of music they enjoyed listening to or the television programmes they preferred to watch

The service had a complaints process in place. However, this information about how to raise a complaint was not routinely shared with people and their relatives. People we spoke with told us they did not know how to complain, comments included, "I don't know how to make a complaint" and "It is a weird place, it isn't run properly at all and there isn't anyone you can go to complain." We saw that complaints that had been received had been responded to correctly, by the previous registered manager, in line with complaints process. Following our visit to Haven Lodge Care Centre, a person's relative contacted us to share their complaint with us. They told us they had made a written complaint to both the manager in June 2018 and the provider in July 2018 some time ago but had not received any response. We contacted the manager

about this and they told us they had not received the complaint at the service but the provider had but had not yet responded, in line with the timeframes contained in the service's policy.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well-led and has not met the required standards since September 2014.

At our comprehensive inspection in November 2016 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the February 2017 inspection we served a Warning Notice for this regulations as the provider's quality assurance systems were not in place or effective at identifying shortfalls relating to infection control, personal evacuation plans and medicines management, which required the provider make improvements by May 2017. At the inspection in July 2017, we found some improvement although these were not sufficient and records still required action.

We conducted a further focused inspection in February 2018, we found that whilst the provider was now meeting some of the regulations they had previously breached, they were still in breach of Regulation 17. We found improvements had been made regarding the areas highlighted found at the focused inspection and the service was now meeting the conditions of the warning notice issued in February 2017.However, the service have been in breach of regulation 12 and 17 since January 2016 and this inspection further identified that these regulations remained in breach showing leadership and governance arrangements were still not effective.

We saw a range audits were being completed, some of which were effective in identifying issues and ensured they were resolved. However, not all audits such as medicines and care plan audits had not identified the issues we found , for example, the weights of some people were not audited, and weight issues were overlooked and people did not receive the appropriate care and treatment. The provider and regional manager had oversight of all audits conducted. The provider used their dependency tool to calculate staff numbers and the regional manager who made regular visits to the service monitored the paperwork relating to staff. However, they had not identified the shortfalls found at this inspection.

There were no records available of pharmacy visits or audits to monitor and review medicines administration and management.

The manager had not reviewed all the complaints that had been received. The manager and provider had failed to ensure the complaints investigation was in line with their policy.

The manager confirmed there had not been any residents or relatives' meetings for some months and no yearly survey had been conducted for staff, residents or relatives to give feedback on the service they were giving or receiving. This was confirmed by a relative who said," I have not been offered the opportunity to give feedback about the service, though I feel confident raising any issues or concerns as there is an open-door policy here."

The service was not adhering to the General Data Protection Regulation (GDPR), which came into effect in May 2018. The manager told us that they did not know anything about it so had not by ensured people, and staff had the relevant information about how it affected them. The manager had not received any

information or training from the provider. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. We noted that the full names of staff and the times of their shifts were displayed in the reception area. We asked the manager about this and whether staff had agreed to this. They explained that they had been told by the regional manager to do this.

The provider was not keeping us informed of all incidents that they are required to inform us of. We had found one incident where a person living at the service, had suffered unexplained bruising to their arm and according to the incident report it was thought to be due to staff error. We spoke with a senior member of staff about this and they acknowledged this should have been sent to the commission as a notification and to the local authority safeguarding team. The notification still has not been received by the Commission.

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

Since our last focused inspection February 2018, the registered manager and deputy manager had left the service. At the time of this inspection a new manager had been recruited. They had only been in post for a very short period. The provider told us they were committed to supporting the manager with the requirements for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons '.

People and their relatives gave us mixed views on the new manager. One person told us, "No I don't know who the manager is." Whilst relatives said, "I think the Manager is very responsive, if I was unhappy I would speak to [name] though I haven't needed to make a complaint. I can speak to the Manager any time, so there really isn't a problem and she is very gentle and respectful" and "The Manager (not the registered manager) and Deputy Manager left in June, though I was not notified and it would've been nice to know what was happening."

Feed back from staff was that morale was, "Poor." Staff spoke highly of the manager. However, they unanimously said they felt unsupported by the provider. Comments included, "[The manager] is trying but has been put in a difficult situation. They're listening but they've got their hands tied" and "The manager is very approachable and really listens. We're all trying our best for [the manager]." One staff member said, "Since [manager's name] has been in post we've had more staff meetings and staff do feel able to speak up."

Staff said they did not feel valued by the provider. One staff member said, "I don't feel valued at all. We're just numbers, not people." Feedback about senior management was also poor. Comments included, "[The provider] is very rude to staff, brutal. [They] come here, stir the pot and then leave" and "[The provider] is no support to me."

Other staff comments included, "In this situation here, no matter what your training and experience, you cannot provide good care" and "It feels like we're climbing the tallest mountain and we're never going to reach the top." One member of staff said, "I can walk out of here at the end of my shift with my head held high. I know I've done my best. The residents and their families are happy and that's the most important thing to me. However, other comments from staff included, "Sometimes, I've left here in tears" and "I find it hard to sleep at night. I worry so much about this place."

We were told by the maintenance person that they were now responsible for organising staff meetings. To date they had had one meeting since the previous registered manager left the service. The manager told us that there had not been any regular staff meetings for some time following the departure of the previous registered manager and their replacement. The manager acknowledged that regular staff meetings needed

to occur to support staff effectively.

The manager acknowledged during our visit that the quality of care people received especially on Sycamore, the nursing floor had fallen below their and the provider's expectations. They told us this was due to poor staffing levels and inconsistent nursing staff.