Lanemile Limited

Haven Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on the 5 and 6 September 2018.

At the last inspection carried out on the 19 April 2017 three breaches of regulatory requirements were identified in relation to Regulation 12 [Safe care and treatment], Regulation 17 [Good governance], and Regulation 20 [Duty of Candour]. The service was not rated as this was a focused inspection. In line with our methodology at the time we did not award a rating or change the previous rating because we were not able to make judgements about all aspects of the service

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve.

At this inspection, we found improvements had been made and the service is rated as 'Good' across all domains.

Haven Lodge is a care home which provides accommodation, personal care and nursing for up to 50 older people who may also be living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 50 older people including people living with dementia in one adapted building comprising of two units. One of the units specialises in providing care to people living with dementia and mental health needs whilst the other provided for people who were physically frail and or receiving palliative, end of life care. At the time of our inspection there were 36 people living at the service.

There was a registered manager. 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.

People said they were safe and had no concerns about the care and treatment they received. Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse.

Risks to people's safety had been assessed and guidance provided for staff with steps to take to mitigate the risk of harm.

Effective recruitment processes reduced the risk of unsuitable staff being employed. There were enough staff available to meet people's needs. Training and supervision systems provided staff with the support, knowledge and skills they needed to carry out the role for which they were employed.

People's nutritional needs were met and people were supported to have enough to eat and drink. A range of external health care professionals worked with the staff team to support people to maintain their health and well-being.

People were supported to have choice and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Care plans were personalised and gave staff guidance on the care and support each person needed. People were encouraged to participate in a range of varied group and personalised activities.

People and relatives spoke positively about the management team. A number of audits and checks were used to ensure the effectiveness, safety and quality of the service.

People and their relatives were given opportunities, such as meetings and annual satisfaction surveys to give their views about the service and comment on how it could be improved.

Further information is in the detailed findings below.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and staff knew how to respond to abuse.

Risks were assessed and guidance provided for staff to mitigate the risk of harm to people health, welfare and safety.

Medicines were managed safely.

There were systems and processes in place to minimise the risk of cross infection.

Staff were recruited safely and the numbers of staff seen during our visits met people's needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been provided with training and development opportunities.

People received enough to eat and drink and specialist needs were catered for. When needed people had access to specialist support.

The service worked in accordance with the principles of the Mental Capacity Act 2005.

People had access when needed to health and social care professionals.

Is the service caring?

Good

The service was caring.

Apart from one incident observed people told us they were treated with dignity, respect and kindness.

Wherever possible, people were involved in making decisions about their care and their representatives appropriately involved.

Staff knew people well and took account of their needs and preferences in how they lived their lives.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs.

Staff were provided with guidance in care plans to meet people's needs and support them safely.

People had access to a range of activities that suited their needs and interests.

There was a complaints process in place which showed concerns were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

People knew the management team and how to access them.

There was an open and transparent culture in the service.

Staff were supported by the management team with a structure that ensured staff were clear as to their roles and responsibilities.

Systems were in place to monitor the quality and safety of the service and lessons learnt from incidents to plan for on-going improvements.

Haven Lodge

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 comprehensive inspection was unannounced and took place on the 5 and 6 September 2018.

The inspection team consisted of two inspectors a Specialist Adviser and one Expert-by-Experience. On this occasion our specialist was a nurse with experience with working with older people, including those who have lived in residential care. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service, and their expertise was in the care of older people.

Prior to our inspection we looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

We spoke with 12 people who could verbally express their views about the quality of the service they received and seven people's relatives. We observed the care and support provided to people throughout the two days of our inspection.

We spoke with the registered manager, the regional director, the operations support manager, the deputy manager, two nurses, 10 care staff, the cook, maintenance staff and one visiting healthcare professional.

To help us assess how people's care and support needs were being met we looked at records in relation to ten people's care. These records included their care plans, management of medicines and monitoring records in relation to the care support provided. We also reviewed records relating to staff recruitment, staff rotas, staff training and systems for monitoring the quality and safety of the service.

Good

Is the service safe?

Our findings

All the people and their relatives we spoke with were complimentary about the care and support they received. People told us they were safe and felt secure with all of the staff who supported them. Comments included, "In general I am satisfied. Staff are very good, I am happy here and well looked after." And "It's quite a nice place here, I have no concerns or complaints to speak of."

At our previous inspection we found the provider had not met the requirements of Regulation 20, Duty of Candour and therefore did not promote a culture of openness and transparency. This included a lack of action taken following incidents to investigate and keep people's representatives informed. In relation to one incident there was also a failure to provide an apology to one person's family and a lack of analysis and lessons learned.

At this inspection we found action had been taken to learn from this incident. A duty of candour log had been implemented. This provided an audit trail of incidents and accidents with follow up actions. This included a record of action taken to inform people's representatives by telephone and copies of follow up letters sent.

Policies in relation to safeguarding and whistleblowing reflected local procedures and relevant contact information. Staff demonstrated a good awareness of safeguarding procedures to follow should they have concerns, including a knowledge of who to report to if they witnessed or heard any allegation of abuse. One member of staff told us, "I know the people who live here well, and I would have no problem whistleblowing if I saw something wrong." The registered manager had demonstrated their knowledge of local safeguarding protocols as they had managed recent incidents well reporting appropriately.

Risks to people's safety had been assessed and their safety monitored. Systems were in place to identify and reduce the risks to people. Care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage these. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. Fire safety was monitored, lifting equipment and call bells were tested regularly and serviced appropriately. Water tests were carried out to ensure the water temperature did not pose a risk to people. The risk of legionella bacteria had been assessed and actions taken to reduce the risk. Health and safety audits were carried out and action plans produced with follow up recommendations where shortfalls were identified.

We saw that risks, such as those related to moving and handling, prevention of pressure sores, and the risk of choking had been assessed. Actions to reduce these risks were well documented in care plans. Risk assessments reflected people's current needs and were subject to regular review. Staff also discussed incidents and concerns at supervision and at daily handover meetings.

Falls were analysed each month to detect any patterns or trends to see if any further measures were needed to reduce the number of falls. Follow up action had been taken to refer people appropriately for specialist

advice and support. Equipment to alert staff when people at risk of falls got out of bed such as a sensor mats were in place to alert staff and mitigate the risk of harm.

We received mixed views regarding the availability of staff to meet people's needs. Comments from people included, "Staff are very good, but they are a bit short at times. They are very, very busy and come to you as soon as they can", "When I ring my alarm they are very good at coming when you need them. Sometimes I have to wait a little longer, but I've never had an accident.", "When they are all here its fine, at weekends it's about the same now that they have empty rooms, if they were full they would be more busy. They still get the work done that you need them to do." And, "As far as I am concerned there are enough staff, if you need any help they are there. Mind you I think they are hard pushed at times."

During the two days of our visit we observed enough staff to meet people's needs. Staff responded to call bells promptly and had time to spend with people chatting. Staff were deployed effectively to keep people safe, a staff member was always present in the communal areas and therefore on hand to ensure the safety and wellbeing of people.

Staff employed at the service had been through a robust recruitment process before they started work. Permanent staff, agency staff and volunteers had checks in place from the Disclosure and Barring Service (DBS) to establish if they had any criminal record which would exclude unsuitable staff from working in this setting. Interviews took place to establish if staff had the skills and qualities needed to carry out the role safely and effectively.

Medicines were managed safely in line with national guidance. People told us they had confidence in staff who supported them with the administration of their medicines. Care plans detailed the support each person required to take their medicines as prescribed and in a manner of their choosing. Medicines were administered by staff who had received training and regular competency assessment. A new electronic system had recently been put in place with a new pharmacy provider.

People were protected by safe systems for the storage, administration and recording of medicines. Medicines were kept securely and at the right temperatures so that they did not spoil. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled staff to know what medicines were on the premises.

We saw staff administer people's medicines safely, by checking each person's medicines with their individual records before administering them, to confirm the right people got the right medicines. Medicines administration (MAR) records were completed accurately and stocks tallied with balances recorded.

There were checks of medicines and audits in place to identify any concerns and address any shortfalls. Staff followed the guidance in place for managing 'when required' medicines. There were instructions for staff about giving medicines people could take as and when they were needed, which ensured people had prescribed access to pain relief or laxatives. Administered medicines were documented on each occasion with the reasons why staff had administered these medicines.

People were protected by the prevention and control of infection. People spoke highly about the standard of cleanliness in the service. Measures were in place to reduce the risk and spread of infection and ensure the regular cleaning of the service. Staff, including domestic staff, were knowledgeable about infection control and received training with regard to COSHH (Control of Substances Hazardous to Health) regulations.

Good

Is the service effective?

Our findings

People told us staff who supported them had the skills they needed and knew their needs well. One person said, "They look after me well, they are all very kind and helpful. I am offered a bath when I want and need one. My only complaint is that some spend time moaning about each other to me which you just don't want to hear." Another told us, "They certainly think they know what they are doing, I think they do most of the time, the staff are satisfactory. The usual staff are very good."

A relative told us, "They are pretty good and appear to know what they are doing. The other day [relative] was very sick, the carer was lovely holding [relative's] hand and stroking their head to calm and reassure them."

Care staff received a wide range of relevant and person-centred training to develop their skills and knowledge and understanding of people's specific needs. Training provided included a mixture of face to face and e-learning. Training covered subjects such as caring for people living with dementia, nutrition, moving and handling, fire safety, infection control, safeguarding, first aid equality and diversity and food hygiene.

Staff were supported with regular one to one supervision and staff meetings which enabled them to discuss their training and development needs. Staff also had observations of their practice and were guided in how to improve their practice in areas if this was needed. Systems were in place to alert the management team when staff supervisions and appraisals were due and this was monitored by senior manager's.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations were in place to lawfully deprive people of their liberty when assessed as in their best interest to keep them safe. The registered manager demonstrated a good understanding of their roles and responsibilities and how the Mental Capacity Act 2005 should be applied. They had developed a DoLS tracker to ensure there was effective monitoring of applications and action taken where reviews were required.

Staff had been provided with training in MCA and DoLS and were clear about people's right to make decisions, including decisions which might be viewed as poor decisions. We saw that Best Interest decisions had been appropriately taken on behalf of people who had been assessed as being unable to decide for themselves. We also saw that, where required, applications had been made to the local safeguarding authority when it was deemed that someone needed to be deprived of their liberty to keep them safe.

Staff asked people's consent before providing them with care and treatment. People's capacity to consent to aspects of their care and treatment was documented in their care plans and signed by them or their relatives, if appropriate. For example, support with personal care and the management of their medicines. Care plans made people's wishes clear with regard to whether they wished to be resuscitated should they

suffer a cardiac arrest. Appropriate DNACPR orders (do not attempt cardio pulmonary resuscitation) were in place for people who wanted this and staff were aware of who had these in place. A DNACPR is a legal order which tells medical professionals of the person's wish not to have cardiopulmonary resuscitation performed on them.

People had access to a balanced, nutritious diet. People were offered choice and food presented in a visually pleasing manner. People were complimentary about the quality and variety of food provided. Comments included, "The food is pretty good", "I have no complaints about the food it is very good" and, "Meals are nicely presented and if you don't like something they offer you alternatives."

During meal times staff were attentive and supported people where required with eating their meals without rushing and the cutting up of food where needed. This was all carried out in a discreet, dignified manner.

People's nutrition and hydration needs had been assessed to support their wellbeing and quality of life. We saw that the risks of people receiving inadequate food and fluid were effectively managed. Care records contained malnutrition assessment tools which were in use and people's weights were regularly monitored. We saw that where required professional advice was sought promptly in the event of weight loss when sudden or unexplained. Care plans contained detailed information to guide staff as to the support required for people at risk of choking, including the required consistency of food. This was also available to kitchen staff involved in the preparation of meals. People were offered a variety of diets for their specific needs. For example, chopped, pureed, low fat, low salt and met the needs of people with a diagnosis of diabetes.

A visiting dietician told us they met with nursing staff monthly to asses and review people at risk of inadequate food and fluid intake as well as the care and a review of people with a percutaneous endoscopic gastrostomy (PEG) in place. This is a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus. Staff followed the recommendations for specific textured diets and had a good knowledge of people's dietary needs and preferences.

We observed people being offered drinks and snacks. For people who could help themselves drinks and snacks of chocolate, crisps, fruit or biscuits were available from nutrition and hydration counter in the communal lounges.

Staff were knowledgeable about people's healthcare needs and current health conditions. Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls team, continence service, opticians, occupational therapists, dieticians and chiropodists. People told us staff responded quickly if they became unwell.

People's rooms were personalised according their preference and taste. People told us they were pleased with their rooms which for some had items of personal furniture, cherished ornaments and photographs.

The service was designed to meet the needs of people with limited mobility and specific health care needs. This included lifts, specialist baths, appropriate grab rails and handles with chairs and wheelchairs designed for specific needs. Staff told us they had adequate equipment to meet people's needs safely. However, we discussed with the registered manager the lack of dementia friendly sign postings and attention to the environment to aid reminiscence. In response to our feedback, by the second day of our visit, work had been started to improve previously un-utilised communal areas. Items had been purchased to aid reminiscence and furniture moved to create a more pleasing, homely environment for people to enjoy.

Good

Is the service caring?

Our findings

All the people and their relatives who we spoke with were positive about the standard of care provided and the kind and caring manner of the staff. Comments included, "I don't sleep well and at night they make me a cup of tea", They look after me well, they are all kind and helpful.", and "The staff are really lovely, very good, considerate, always concerned that you've got what you need."

We observed positive interactions between staff and the people they supported. We saw that people were comfortable in the presence of staff as people were treated with genuine warmth. However, we observed one incident where a member of staff spoke abruptly to a person in an unkind manner, abrasive. We discussed this with the registered manager who in response took action immediately to address this with the staff member involved. Other staff demonstrated a passion to provide compassionate, attentive care and knew the needs of people well.

People and their relatives told us they valued their relationships with staff. One person told us, "There are some I have a good relationship with and we chat about things." A relative told us, "There are staff here I can go to who will update me. Some of the staff have a lovely rapport with [relative]." Another said, "All of the staff are very friendly. Staff will laugh and joke with [relative]. They have a life story book and the staff have added bits and pieces to this. I do feel they treat [relative] as an individual, it's very personal and I see them treating others in the same way."

People were encouraged to be involved in the choices around all aspects of their care such as what they had to eat, what time they got out of bed, what they wear and the gender of care staff supporting them. We saw that those choices were recorded in people's care plans and were in line with the care that people and their relatives told us they received.

People told us family and friends were able to visit without restriction, "I visit every day, it is important for me to be here. I can support [relative] with meal times and stay as long as I like. No one interferes."

People's dignity and privacy were respected. We spent time observing the care practices in the communal areas and saw that people's privacy and dignity were maintained. Staff knocked on people's doors before entering and made sure they were happy for them to enter the room. Staff were not rushed and respected people's choices as to where and how they spent their day. One person told us, "I like the quiet of my room. They know I like to stay in my room and have my meals here."

Good

Is the service responsive?

Our findings

Prior to admission people's needs had been assessed. People and or their representatives, where appropriate, were involved in making decisions about their care and support.

Care plans had been tailored to the individual and contained information about their health, welfare and safety needs and how they communicated. These were regularly reviewed to reflect people's current needs. However, care plans we reviewed had not been signed by people and or their representatives to evidence their agreement with its contents.

People received care that was responsive to their needs because staff knew them well. Care plans were informative and documented the support people needed and how they wished it to be provided. Details such as how people chose to spend their time, steps staff could take to enable people to maintain their independence and how their daily routines, care and support needs were to be met. People with limited verbal communication were encouraged to be independent. Staff described people's opinions as to how they wished their care and support to be provided and how to promote their independence. Care plans were regularly reviewed and updated to reflect people's current care needs.

Staff attended daily handovers at the start of each shift. These provided staff with up to date information about people's needs and kept staff informed as needs changed. Staff wrote daily records detailing are and support provided and how people had spent their time. Daily records were completed by staff and showed us that people's food, fluid, weight, blood pressure and pulse had been monitored on a regular basis and an effective bowel monitoring system was in place. Staff told us handovers were informative giving them the information they needed to provide the right care for people.

Some people had difficulty accessing information due to their health needs. Care plans recorded when people might need additional support and what form that support might take. For example, some people had impaired hearing or restricted vision. Care plans stated if they required hearing aids or glasses. People's oral health care was assessed and information transferred to their plan of care to support people to maintain good oral hygiene and prevent the risk of health related complications.

When needed the service provided end of life care for people. People's needs and wishes regarding their end of life care was documented appropriately. Life history books had been produced which staff told us, "These books help us to see not just the person as they are now but a life lived with an understanding of where they have come from, what work they used to do and what is important to them."

People had access to a range of group and one to one activities appropriate to their needs. Activity organisers known as lifestyle coordinators were employed to support people with organising activities and events. Group activities included gentle exercise, arts and crafts, sing along sessions and cake decorating. People told us they enjoyed one to one manicure sessions as well as support reading newspapers and newsletters. One person told us activity staff read a prayer with them which they valued as this was important to their sense of wellbeing.

There was a complaints process in place which showed concerns were investigated, responded to and used to improve the quality of the service. There was a clear system for logging concerns, suggestions and complaints. We noted that all concerns and complaints had been taken seriously and responded to in a timely manner with a clear audit of actions taken in response to concerns.

People and staff said that they were supported to voice any concerns they might have and the registered manager had been supportive in listening to suggestions they had made to improve the service through regular resident's meetings and annual satisfaction surveys.

Good

Is the service well-led?

Our findings

At our last inspection we found monitoring and governance systems to ensure safe moving and handling of people were ineffective. This included ineffective staff training, risk assessments and the lack of suitable lifting equipment. Handling plans did not contain the information needed to guide staff in moving people who were unable to mobilise safely.

At this inspection we found improvements in the overall clinical governance with improved systems for quality and safety monitoring. People's needs in relation to moving and handling had been reviewed and appropriate equipment in place. Moving and handling plans were available to staff in each person's room where relevant with clear, detailed information with photos and a description of the type of equipment and how this should be used.

The management team carried out regular quality and safety monitoring of the units. This included a review of care plans and regular clinical audits all of which were documented and included a record of their findings and responses to any shortfalls identified. Daily 'ten at ten' meetings were held for staff to discuss any concerns and for staff to receive updates as well as handovers at the beginning of each shift.

Management audits, included the monitoring of hospital admissions and discharges, safeguarding concerns, falls, wound and weight monitoring, including the audit and management of medicines errors. Other quality audits included a review of health and safety of the premises including fire safety water temperature testing relevant to prevent the risk of scalding and legionella. We saw documentary evidence that these took place at regular intervals and any actions identified were addressed with timescales for actions to be completed.

The provider received regular updates from the management team to enable them to analyse trends in areas like falls, infection rates, incidents and pressure sores. By identifying trends, the management team planned action they would take to reduce the amount of incidents occurring and so fulfil their purpose to promote people with safer and healthier lives. This they planned in partnership with other healthcare agencies such as GP's and dieticians.

There was a manager registered with the Care Quality Commission (CQC) with overall responsibility for the service. They were supported by a deputy manager who was also the clinical lead responsible for the clinical governance of the service. Each unit had a designated nurse responsible for the day-today management of their unit and the direct supervision of staff.

The registered manager had reported incidents when required to do so to CQC. We found on day one of our visit the provider had not displayed the most recent inspection report within the service for people to view. Following our feedback this was quickly rectified.

Staff told us, "The morale is pretty good here. We work as a team and try to support each other as best we can." And, "The manager and deputy manager are very approachable and their door is open to us should we

have any concerns." Staff also told us they had access to air their view through staff meetings and annual surveys. One told us, "We can always discuss things openly with either our senior or the management."

People's and their relatives told us the registered manager operated an open door policy and were confident that any issues they raised would be dealt with promptly. Staff told us they could make positive suggestions and people could speak up if they had concerns or ideas. We saw that both staff and resident meetings were held on a regular basis so that people were kept informed of any changes to work practices, health and safety management or anything,
which might affect the day-to-day management of the service.

Annual satisfaction survey feedback had been formulated into action plans. The registered manager told us comments and feedback they received helped them to plan to improve future service development.