Simon Greaves

The Haven Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection was unannounced and took place on 5 November 2014.

The Haven Rest Home is registered to provide accommodation and personal care for adults with a dementia related illness for a maximum of 17 people. There were 16 people living at home on the day of the inspection. There was a registered manager in place. 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 told us that they felt safe and well cared for with enough staff to meet their needs. Staff were able to tell us about how they kept people safe. During our inspection we observed staff were not always available to meet people's care and social needs because incidents had not been reviewed to prevent them from happening again.

Summary of findings

This was because at times we saw that people were left in the communal lounge where staff had not been available. We saw that at time this put people at risk of falls or injury.

We have made a recommendation about assessing people's individual health and environmental risks.

The provider was not reporting safeguarding incidents to the local authority and CQC in line with their legal responsibilities. This would ensure that people were protected and the appropriate investigations were completed relating to each person involved. The provider was not meeting this regulation.

People received their medicines as prescribed and at the correct time. However, we found systems and processes needed to be improved to ensure people were given medicines that were stored and able to be identified correctly. This would ensure people who required medicines as needed received them when required. The provider was not meeting this regulation.

People told us they liked the staff and felt they knew how to look after them. Staff were provided with training which they felt reflected the needs of people who lived at the home. However, staff did not demonstrate a full understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At the time of our inspection three people had an application submitted to deprive them of their liberty. The registered manager had been supported to make these applications on the advice of social workers.

Assessments of people's capacity to consent and records of decisions had not been completed in their best interests. The provider could not show how people gave their consent to care and treatment or how they made decisions in the person's best interests. Therefore, people had decisions made on their behalf that may not have been in their best interest. The provider was not meeting this regulation.

People and relatives told us there were enough staff to support people at the home. Staff at the home felt there were enough staff to meet the needs of people living at the home. They also told us that extra staff were available at busy times if required.

People were supported to eat and drink enough to keep them healthy. We found that people's health care needs were assessed, and care planned and delivered to meet those needs. People had access to other healthcare professionals that provided treatment, advice and guidance to support their health needs although these had not always been followed.

People told us and we saw that their privacy and dignity were respected and staff were kind to them. However, on occasions we saw staff had not always been understanding and supportive of people's choice and decisions.

We have made a recommendation about staff training on the subject of dementia.

People had not always been involved in the planning of their care due to their capacity to make decisions. However, relatives told us they were involved in their family members care and were asked for their opinions and input.

People told us they would prefer more things to do during the day. People said that they did go out occasionally. People we spoke with told us they were not aware of the provider's complaints policy, however were confident to approach the manager if they were not happy with their care.

We have made a recommendation that people living with dementia related illness receive care and support to maintain their hobbies and interests.

The provider and registered manager made regular checks to monitor the quality of the care that people received and look at where improvements may be needed. However, we found that improvements were needed to ensure that the audits helped the provider to identify where regulations were not being met.

We have a made a recommendation about developing and supporting the registered manager and staff knowledge to provide care that reflects current MCA legislation and dementia care best practice.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People received their medicines, however improvements were needed in managing people's medicines. The manager had not identified or reported safeguarding concerns to the local authority for investigation. People told us they felt safe and looked after by staff.

People and relatives told us they felt there were enough staff on duty to meet the care and social needs of people who lived at the home.

Requires Improvement

Is the service effective?
The service was not effective.

People's needs and preferences were supported by trained staff.

The Mental Capacity Act (2005) code of practice was not consistently followed to ensure people were supported to make their own decisions.

People's dietary needs had been assessed and they had a choice about what they ate. It was not always clear how input from other health professionals had been used when required to meet people's health needs.

Requires Improvement

Is the service caring?
The service was not caring.

People received care that met their needs. Staff provided care that met people's needs whilst being respectful of their privacy and dignity and took account of people's individual preferences. However, it was not always clear how people had been involved in their own care.

We found that some staff required further support to ensure that people were treated in a way that made them feel included and valued at all times.

Requires Improvement

Is the service responsive?
The service was not responsive.

We saw that people were able to make some everyday choices. However, people had not been engaged in their personal interest and hobbies.

People were supported by staff or relatives to raise any comments or concerns with staff and these were listened to.

Requires Improvement

Is the service well-led?
The service was not well-led.

Requires Improvement

Summary of findings

The registered manager and provider monitored the quality of care provided. However, improvements were needed to ensure effective procedures were in place to identify areas of concern identified during this inspection.

People, their relatives and staff were very complimentary about the overall service and felt the registered manager was approachable and listened to their views.

The Haven Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 November 2014 and was unannounced. The inspection team comprised of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law. No concerns had been shared from the local authority.

During the inspection, we spoke with five people who lived at the home and three relatives. We spoke with five care staff and the registered manager.

We looked at five records about people's care, staff duty rosters, complaint files, meeting minutes and quality audits that the registered manager and provider had competed.

Requires Improvement

Is the service safe?

Our findings

Staff we spoke with told us that some people who lived at the home displayed behaviours which challenged others. One member of staff told us, "If they get angry, we try and calm them down." However during our observations we saw that one person frequently became agitated with other people at the home, which upset them. Staff did not intervene or try to distract the person to keep others safe. Staff had not been able to identify the cause of this person's behaviour or how to intervene in a timely way to keep people safe. There were no detailed instructions for staff in people's care plan to describe their triggers or interventions they should use if the person became agitated, upset or angry with others at the home.

We saw that staff had recorded incidents and accidents, however these had not always been reviewed or seen by the registered manager. This was because staff had recorded these in the daily notes and not followed the provider's policy on reporting and recording incidents. People had not been protected from a repeat of these incidents. These incidents should have been referred to the local authority safeguarding team for investigation. However this had not been done. For example, records showed there had been seven incidents involving one person at the home which the registered manager had not been aware of. This meant that the registered manager had not been able to take action to ensure there was not a repeat of these incidents and to maintain people's safety.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2010.

We observed staff administer medicines to people who lived at the home. One person told us, "I take some tablets, can't remember what they are for but the girls will tell me". Staff provided an explanation of the medicines. For example, one person had seen their GP the day before and required a short course of medicines. The staff member reminded the person of this to ensure they understood the reason they were taking the medicine.

We found that no temperature checks had been undertaken of the medicines that were stored in the fridge. People could be given medicines that were out of date and ineffective. There was a label missing from one tub of cream and we found that others creams had faded labels. Staff were unable to confirm who the medicines were for. In addition, where people had been prescribed medicines as and when required, there was no guidance for staff to follow on when and how to administer them. For example, we found that staff had administered one person's, as required medicine, every morning at the same time and an incorrect dosage. This meant staff had not taken into consideration whether the person had required it to manage their condition correctly.

The medicines in the home had not been monitored effectively to ensure people had received them safely and as prescribed. People were at risk as there was no assurance their medicines had been stored, monitored or administered correctly. The registered manager told us that they checked the medicines but had not recorded their findings.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Accommodation for persons who require nursing or personal care) Regulations 2010.

We saw that some risks to people had been assessed and actions put in place to reduce the risk of harm to people. However, we identified risks that had not been assessed. For example, one person's record showed they had lost a significant amount of weight in recent months. We found their nutritional needs had not been assessed since May 2014 and no action had been taken to review how the weight loss would impact on their health.

Throughout the day we saw staff were not always available to support people's mobility needs in the lounge. For example, we saw people struggling to lift their frames to get over a high step between rooms which placed them at risk of falling and potential injury. The registered manager and staff were not able to show how this risk had been assessed for each person at the home and how they should be supported to move between these rooms. The safety and welfare of people had not always been protected as not all risks had not been assessed or reviewed and the provider had not taken actions to protect people.

We recommend that the provider seek advice and national guidance about assessing people's individual health and environmental risks.

We asked people who lived at The Haven Rest Home if they felt safe. One person we spoke with told us, "I feel safe here; the staff are good to me." Another person told us, "I am safe, I am amongst friends."

Requires Improvement

Is the service safe?

All staff we spoke with told us they understood their responsibilities in relation to raising concerns about people's safety. They told us they were confident about recognising and reporting abuse. Staff were aware of how to escalate concerns to the registered manager or senior management. Staff also knew how to raise any concerns with external agencies such as the local authority.

People and relatives we spoke with felt the staff were available to them and felt they did not have to wait for things when they asked. One person said, "They [staff] are always here". The registered manager told us they had assessed people's needs to ensure that there were enough staff to meet the needs of the people. Staff we spoke with also told us they felt there were enough staff to look after people at the home and more staff would be 'called in' or did additional shifts to cover shortfalls if required throughout the day.

Requires Improvement

Is the service effective?

Our findings

We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a law about making decisions and what to do if people cannot make some decisions for themselves. DoLS are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom. At the time of our inspection three people had an application submitted to deprive them of their liberty. The registered manager had been supported to make these applications on the advice of social workers.

Staff did not have a comprehensive understanding of the MCA or DoLS. Staff were not aware of the requirements of the MCA and did not know if people had consented to their care and support. The manager did not have an understanding of how the Act applied to their role and the human rights of the people living in the home. Training had been provided to staff in understanding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). However, this training had not been effective in increasing the staffs knowledge and how it related to people they cared for. Therefore, people had not been looked after in a way that does not inappropriately restrict or deprive them of their freedom.

People's capacity to make decisions or consent to their care had not been assessed. For example, when making a decision to use bedrails for one person who lacked capacity to make the decision there had been no best interest assessment made. The provider could not be assured they delivered care and treatment to people that gave their consent or the decision had been in their best interests. This meant people had decisions made on their behalf that may not have been in their best interest.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our observations staff demonstrated that they had been able to understand people's requests and had responded accordingly. For example, when people required help with personal care. Staff were aware of people's personalities when talking with them and were able to tell us about the person's life history.

We spoke with three staff and they told us that they felt supported in their role and had regular meetings with the registered manager. One said, "Lots of support here to be honest". Staff told us they had received training that reflected the needs of the people they cared for and future training was arranged as needed.

We observed people having their midday meal. We saw the food was well presented and people commented that it was "Tasty." We saw people were supported where necessary to eat their meal. One person told us, "The food is good but we don't get drinks very often." Another person told us, "The food is lovely, there is not much choice but you have to fit in with everyone else when you live in a home." We spoke with staff who told us there was a menu planning system in place. One member of staff told us, "We cook the main meal at lunchtime. If people don't want that meal then we will provide them with something else." They also told us that people were offered drinks regularly and were available if requested.

Staff understood the need for healthy choices of food and people's individual likes and dislikes. However, when we spoke with two staff they were not always able to tell us about people's nutritional needs. For example, they were not aware of the recent significant weight loss of two people or of the action required to ensure people maintained a healthy weight. People had been regularly weighed, however no action had been taken or recorded to ensure people remained at a healthy weight or had been referred to other health professionals for advice.

We found people's fluid intake was not always recorded, so it was not possible to determine if people were receiving sufficient fluids for their needs. One person's care record showed they had been treated for an infection and stated that staff should 'push fluids'. We found there was no record of the person's recommended fluid intake or that the person's actual fluid intake had been monitored. Therefore, it was not clear if the person's care plan was being followed to maintain their dietary needs.

All of the people we spoke with told us they had access to health care, such as dentist, district nurses and opticians if they needed one. One person told us, "I have been practising my walking. A physiotherapist used to come and see me to do exercises to help improve my walking. I am much more independent now". Another person told us, "I have my eyes tested and see the dentist". We spoke with a health professional that visited the home regularly. They told us they felt people received the care they needed and staff were good at responding to people's changing needs.

Requires Improvement

Is the service caring?

Our findings

All of the people we spoke with told us that staff were kind and caring. One person told us, "The staff are really wonderful; they look after me very well." Another told us, "The staff are so lovely, caring and friendly". Relatives felt their family members were cared for in a 'homely' environment with friendly staff. One relative said, "They are inclusive of [person]". Another said, "It's (the home) small enough to care".

Staff we spoke with told us they listened to people's choices. For example, when providing personal care in a way the person had wanted. One staff member said, "We are not here to boss people around. It's not my opinion, but theirs that matter". The registered manager had also arranged for one person to use an advocacy service to support them. In addition, another person had been supported to use a befriending service provided by a charity. This meant that people were supported with services outside the home.

We observed one person had expressed a wish to change their clothes following lunch. A member of staff offered to help them with this. This showed us that staff recognised the importance of people's personal appearance and this respected people's dignity. One person told us, "The staff respect my privacy." Plate guards were used to promote people's independence at meal times and staff always knocked on people's doors before entering and ensured doors were closed when providing personal care.

However, there were times when some staff used louder voices with people. For example, we saw a member of staff supporting someone with their meal. We observed the member of staff say, "Look, you are going to drop it on the floor." We also heard a member of staff say, "Come on, I'm taking you to the toilet." We observed these people had responded in a negative way by shouting back at staff. We also observed a staff member arguing with a person about what they believed had happened to them. We saw this made the person distressed and anxious. Therefore, staff had not consistently listened or responded in a manner that assured the person felt valued and supported. We raised this with the registered manager who told us they would address this with staff.

One staff member we spoke with was able to demonstrate how they would help someone that would be become anxious or distressed. They provided examples of how they would approach people using their knowledge of that person. For example, at different times or understanding that it could be linked to their history.

People we spoke with told us about how they had been involved in their care planning. One person told us, "I tell them what to do. I tell them when I want to go to bed and when to get me up". Relatives told us that they had been asked for their views and opinions when planning their family members care. One said, "They (registered manager) will phone anytime to speak to me about [person] care".

We recommend that the provider sources training for staff, based on current best practice, in relation to care and communication for people with a dementia related illness.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about how their care was planned. One person told us, "I haven't seen a care plan. The staff do ask me from time to time if I am ok." Another person told us, "I haven't been involved in planning my care. I don't know what my care plan is." Relatives told us they were involved in their family members care and were asked for their opinions and input.

People told us they liked the staff and the way the staff spoke with them. Relatives told us they were confident that their relative's needs were met. One relative said, "They always update me when I visit. I am confident in the staff". Another said, "They understand [person] conditions".

On the day of our inspection we found no organised activities to meet people's interests or hobbies were taking place for people. No individual activities plans for people were available. One person told us, "There is not much to do. Most people sleep during the day." Another person told us: "I am happy to stay in and I like to read the paper which I do". We saw that relatives were free to visit and they told us they could visit at any time. We also heard staff chatting with people about who had visited them and who would be visiting them that day. This helped people to maintain relationships that were important to them.

The activities coordinator was not available on the day of our inspection. The registered manager told us that both group and individual activities took place in and out of the home. We looked at the activities plan that was not accessible to people who lived at the home. We found there was no record of activities for people for the previous two weeks. Staff were able to tell us about some group activities that had taken place. For example, Cake decorating and a monthly visit from an external singer.

We looked at four care records and found there was an inconsistent approach to completing people's details. For example, their likes, dislikes and interests had not always been completed. Staff we spoke with were unable to provide an understanding of peoples individual hobbies and interests. This meant that people's care was not planned in a way that was individual to them.

All of the people we spoke with told us they knew who they would raise concern and comments with. They told us they would approach the manager or staff if they were not happy with their care. People we spoke with told us they were unaware of any meetings for people to discuss their views about the care they received or any improvements they would like to see. Relatives told us they were happy to raise concerns direct with the registered manager who had always been approachable and listened to comments or concerns. The provider had set meeting dates for both relatives and people to attend as a result of feedback from relatives at a recent fete at the home. This would help support people to feedback on their experiences and allow the provider to make changes where identified.

We recommend that the provider seek advice and national guidance about how to support people living with a dementia related illness to maintain their individual hobbies and interests.

Requires Improvement

Is the service well-led?

Our findings

People were supported by a consistent staff team. Family members were complimentary about the care of their relative and told us they were listened to and supported. One relative said, "The door (manager's office) is always open and we can just go in a chat about [person].

All of the staff we spoke with told us the home was well organised. They told us they were well supported by their manager and felt able to approach the manager with any concerns they may have. Team meetings also provided opportunities for staff to raise concerns or comments with people's care. For example, staffing pressures and ways to ensure people got the support required for breakfast time.

We found the registered manager and staff were not aware of their responsibilities in relation to the Mental Capacity Act. The manager and staff were not aware of current best practice in terms of managing people's behaviour and dementia care. Their knowledge had not been kept updated in line with current best practice guidelines. The register manager's skills and knowledge needed to be developed to enable them to drive improvements. This would support them to deliver high quality care to people through care staff that had appropriate guidance in line with current best practice.

The provider had identified how they intend to support the registered manager in the PIR. They planned over the next three months to provide a change to the management structure and look at key staff taking responsibility of specific areas of responsibility. For example, medication management and generic environmental and individual risk assessments. These reflect some of the areas we had identified as requiring improvement following our inspection. However, staff we spoke with were not aware of the providers plans for improvement.

The registered manager carried out regular checks of the home with support from an external consultant. The registered manager told us that gaps identified from these checks were actioned but not recorded. For example, we were shown an accident policy and flow chart had been put in place, although staff had not followed this consistently. The registered manager provided their assurance that staff would be made aware of this to prevent further incidents and safeguarding referrals being missed.

In addition the provider regularly visited the service and worked closely with the registered manager to ensure that people received care and treatment that met their needs. They had identified areas for improvement and a plan of action for the development of the registered manager, which they felt would improve the quality of care for people who lived at the home.

We recommend that during this period of improvement the provider seeks advice and guidance from a reputable source, about MCA training and supporting people to express their views in their care, treatment and support.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not protected people against the risks associated with unsafe use and management of medicines as they did not have appropriate arrangements for storing, recording administering and disposing of medicines. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not protected people against the risk of abuse by identifying and reporting incidents to the relevant authorities. Regulation 11 1(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider could not be assured they delivered care and treatment to people that gave their consent or had reviewed in their best interests. Regulation 18.**