Rest Haven Charitable Home Trustees

Rest Haven Charitable Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This focussed inspection took place on 18 and 26 October 2017 and was unannounced on the first day. We had previously carried out an unannounced comprehensive inspection of this service on March 2016 and rated the service as Good overall, although the service was rated as requiring improvement in terms of effectiveness. At that inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities (Regulations 2014. This was because the service was not following all the requirements of the Mental Capacity Act (2005). We carried out a focussed inspection in April 2017 to look at the effectiveness of the service and to see whether the service was now meeting the requirements of the regulation. We found that they were now compliant with this regulation. However, we found that staff were not fully up to date with all their training and had not received supervision from a senior member of staff. We therefore continued to rate the home as requiring improvement in effectiveness.

After that inspection we received concerns in relation to an incident where a person had fallen, and subsequently died. As a result we undertook this focused inspection to look into whether the service was safe, effective and well-led. This report only covers our findings in relation to these areas. You can read the reports from our last comprehensive inspection and focussed inspection, by selecting the 'all reports' link for Rest haven Charitable Home on our website at www.cqc.org.uk

Rest Haven Charitable Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Rest Haven is owned by a charity andhas a board of trustees who oversee the work of the home. Trustees serve on a voluntary basis.

The care home accommodates 34 people in one adapted building. At the time of the inspection, 29 people were living at Rest Haven. Some people had been resident for a number of years. Some people had physical disabilities and a small number of people living at the home had dementia.

The home had 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, relatives, staff and visiting professionals all said that the home was well managed. They said they knew who the registered manager and her deputy were and they were available to talk to whenever needed. The registered manager worked with the board of trustees of the home to ensure they monitored and improved the safety and quality of the care provided. There was evidence that where incidents and accidents occurred, it was reviewed to see whether changes to systems were needed.

People, their families and visitors to the home including health and social care professionals were very positive about the care and support people were given. Comments from people included "I feel safe; staff

look after me well"; "Very nice. They look after me very well, really can't fault anything." A visitor commented "Absolutely amazing place caring for physical and spiritual needs." A health professional commented "It's one of our better homes; I have no concerns at all." There were systems in place for feedback including resident meetings and surveys. Staff meetings were held regularly to ensure staff were able to voice concerns and suggest improvements

People received support from staff who knew them well. Throughout the inspection there were positive interactions between people and staff who worked in a calm and unrushed manner. Staffing levels were monitored to ensure they met people's needs. Staff said, and records confirmed, that they had undertaken training both when they first joined the home and in order to update themselves. Staff were supported through supervision meetings and through observation of their practice.

Staff had received training in the Mental Capacity Act (MCA) 2005 and were able to describe how to support people who may lack capacity to make a particular decision. The home had applied for Deprivation of Liberty Safeguards authorisations for some people living in the home and were working within the requirements of the MCA to keep any restrictions to a minimum. Staff had also received safeguarding vulnerable adults training and understood their responsibilities and what to do if they had a concern.

Medicines were stored, administered and recorded safely. Staff had been trained to administer medicines following the guidelines. Where people self-administered their own medicines, there were checks carried out to ensure they were safe to do so.

The home was well maintained. Audits and checks were undertaken to keep people safe. Risk assessments and care plans described the care people needed to support them. These were reviewed regularly and when people's needs changed. Staff worked with health and social care professionals to address people's physical, mental and social needs. Health professionals said they had "no concerns" about the home or its staff.

People said they enjoyed the food and had a choice of meals. Specialist diets including soft diets were catered for. People were supported to have sufficient food and drink and maintain a balanced diet.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

Risks to people had been assessed and supported people to be safe whilst minimising any restrictions on them. However not all the advice from an external health and safety consultant had been fully completed within the recommended timescales.

People were protected from the risks of abuse by staff who understood their responsibilities.

Medicines were generally stored, recorded and administered safely. However staff did not always ensure that medicines were taken as soon as they were administered.

There were sufficient numbers of suitable staff to ensure people were kept safe and had their needs met.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the necessary skills and knowledge. Staff had updated their training when necessary and received supervision (one to one meetings) with a member of senior staff regularly.

Staff were provided an induction when they first joined and refresher training from time to time.

People were supported to maintain a healthy, balanced diet.

Staff understood their responsibilities in terms of legislation. Where people's liberty was restricted, staff had ensured they worked within the Mental Capacity Act 2005.

People were supported to access health services.

Is the service well-led?

Good

The service remains well–led.

Rest Haven Charitable 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 18 and 26 October 2017 and was unannounced on the first day. The inspection was carried out by one adult social care inspector.

The inspection was prompted by concerns we received of an incident in which a person using the service had sustained a serious injury and subsequently died. This incident is subject to an investigation by the police and, as a result, this inspection did not examine the circumstances of the incident. Instead it looked to see whether the home was providing care which was safe for other people living there. It also checked to see whether the home was well managed and well led.

In particular, the information shared with the Care Quality Commission about the incident raised potential concerns about the management of risks in relation to the safety of the outside environment, the assessment of people's capacity to make particular decisions and the monitoring of the home's safety by the registered manager and trustees.

Prior to the inspection we reviewed information we held on our systems. This included reviewing whether any statutory notifications had been submitted to us. A notification is information about important events which the service is required to tell us about by law.

We spoke with five care staff, three kitchen staff including the cook, as well as the registered manager and their deputy. We met two of the provider organisation trustees who were visiting the home. During the inspection we also met and spoke with two healthcare professionals and two social care professionals.

At the time of this inspection, 29 people were living at Rest Haven. We met most people living in the home and spoke to 10 of them about their experiences. We talked to six relatives and friends of people living in the home.

We looked at a sample of records relating to the running of the home and to the care of people. We reviewed four care records, including risk assessments and care plans. We also looked at five medicine administration records. We reviewed three staff records. We were also shown policies, procedures and quality monitoring audits which related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

The home managed risks to people by assessing and planning for each person's individual needs as well as considering and dealing with the generic risks which could impact people, visitors and staff.

Because an accident had occurred where a person had fallen outside, we checked to see whether all outside areas were safe. Since the incident, the provider and registered manager had undertaken a review of all areas inside and outside the home. They had introduced further safety features to keep people safe. A new gate which required a key code to open it had been installed. This meant that areas which were not designated as communal could only be accessed by staff. As an interim measure, some areas around the raised beds surrounding the back patio had a barrier across. There were plans for gates leading to these areas to be installed. As the raised beds were not communal areas, it was planned that the gates would have locks on them. Additional railings and gates at the front of the building were also planned to reduce the risks to people. When making these adjustments, the registered manager had taken into consideration whether these changes would place unnecessary restrictions on people.

Further enhancements as a precaution to keep people safe in an outside passage which led from a fire exit were also planned. These enhancements included painting an outside wall to make it brighter, painting drain covers to make them more visible and cordoning off an area used for recycling bins. This meant, in the event people needed to use this escape route, they would be at less risk of tripping or falling. The home had also reviewed the safety of exits to ensure that people were kept safe. This included adding alarms to doors leading to the patio, including patio doors in one bedroom and the dining room, as well as a door off a corridor. This meant that staff would be alerted if a person was going out of a door into the back garden. The front door had a keypad which some people, visitors and staff could use to exit the home. The risks of people using the key code had been assessed. Where people were considered not to be at risk from opening the door without staff knowledge, they had access to the key code. Anyone wanting to access the building needed to ring the front door bell and were then greeted by staff before entering. By the second day of inspection, most of these safety features and improvements had been completed.

People felt safe living at the home. Comments from people included "I feel safe; staff look after me well"; "Very nice. They look after me very well, really can't fault anything." Another commented "There are always staff around to help me when I am moving." A visitor said "Absolutely amazing place caring for physical and spiritual needs." A health professional commented that they had "no concerns. My colleagues and I discuss each home at team meetings and we never have any concerns about Rest Haven."

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. For example one person who had been assessed as at risk of falls, was supported to walk around the home as they enjoyed being on the move. The person's care plan described how staff should support them to minimise the risks. This included making sure they had walking aids when moving. People were protected against hazards such as falls, slips and trips inside the home. Staff ensured that corridors, communal areas were kept free from clutter. Staff helped people to use the correct walking frame after lunchtime when they wanted to leave the dining room.

There were arrangements in place to keep people safe in an emergency and staff understood these arrangements and knew where to access the information. Each care record had an up to date personal emergency evacuation plan which described the support the needed in an emergency such as a fire. There were reciprocal arrangements with other local care homes to provide shelter for people if an emergency occurred, although these were not formally documented. The registered manager said they would develop a document which would provide the details of what needed to happen in the event of a catastrophic event making the home uninhabitable.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. The manager and her deputy reviewed all incidents and considered whether there were actions that could be taken to reduce the risks of a similar incident occurring.

People were protected against the risks of potential abuse including financial, physical, emotional and psychological abuse. Staff had received training on how to safeguard vulnerable adults. Staff understood their responsibilities to report concerns. One member of staff said "If I have a concern, I would talk to [registered manager] or a senior." They also explained that they knew they could also report concerns directly to the local authority.

We discussed with the registered manager about incidents which should be reported as a safeguarding concern. They recognised that they had not always reported incidents, for example they had not reported an incident when, on one occasion, it had been reported that two night staff had accidentally fallen asleep whilst at work. This meant that people had been at potential risk of neglect. The registered manager had taken appropriate actions including disciplining the staff. The registered manager agreed that they recognised that they should have reported such an incident as a concern and would ensure they did so in future.

Peoples' medicines were generally managed and administered safely. However, during lunch we observed staff giving medicines which some people chose not to take immediately. Instead they chose to wait until they had finished eating. Although the staff administering the medicine remained in the dining room and made sure each person took their medicine, it was on the table for some minutes. This meant another person at the table could have inadvertently picked the medicine up. We discussed this with the registered manager who agreed to review the timing of the medicines round so that medicines were given at the end of a meal rather than during the meal.

There were protocols in place for medicines which were administered PRN (as required). However, not everyone was asked whether they needed or wanted to take the medicine. This meant that people were at risk of taking a medicine which they did not need at that time. We discussed this with the registered manager who said they would remind all staff who administered medicines to offer PRN medicines rather than to automatically administer them.

Medicines were stored in a locked medicines trolley which was maintained in a tidy and orderly manner. Medicines were clearly labelled. Skin creams and lotions were recorded on topical administration records when administered. This meant it was easy to assess whether people always received their topical medicines as prescribed. Topical creams and lotions were stored safely and were dated when they were opened and when they were due to expire. This helped to ensure the creams used were in-date. Medicines that were no longer required were disposed of safely. Where people self-administered their own medicines, they had been assessed as safe to do so. For example one person had their medicines collected by staff but self-administered their medicines. They had signed an agreement which recorded that staff would undertake a monthly audit of their medicines. This helped to ensure that the person had taken their

medicines and staff did not over-order any medicines that had not been taken. The GP had signed to say that certain homely remedies, such as paracetamol and cough linctus, could be used in the home.

Senior staff and night staff who administered medicines had been trained to do so. Their training was updated each year. Records showed, and staff confirmed, they were up to date with training. Staff were also observed by the registered manager, or her deputy, to ensure they were competent to undertake the role.

Medication audits were routinely carried out. A pharmacist audit visit had been in September 2017 had not identified any issues relating to the management of medicines in the home. Medicine errors were reported. Staff said that medicine errors were discussed as a team to ensure all staff could use them as a learning experience.

The home which was well maintained and kept clean to a high standard to ensure people were protected against the risks of infection. There were no malodours evident during the inspection. Staff were observed using personal protective equipment including disposable aprons and gloves when appropriate, for example when providing personal care.

There were sufficient staff on duty to meet people's needs. Call bells were answered within a short time and staff were observed working without rushing throughout both inspection days. One person said "They come quickly if I ring my bell." Another commented "Staff are really lovely; they have time to sit and chat to me." A relative said there were "Enough staff and they know people well." Another relative commented "Occasionally staff are a bit stretched if they are to supporting one person, but this is the exception rather than the rule." They also said that there were staff who were available to support their family member to go out as they were unable to go out unaccompanied. The registered manager monitored people's needs and adjusted staffing levels at different times. A visiting health professional commented "Always enough staff. I work upstairs and downstairs and can hear them in other rooms. If I need to speak to a member of staff, there is always someone around when I need them."

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.

Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure people were suitable to work with vulnerable adults. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Good

Is the service effective?

Our findings

At the last inspection in April 2017, we found staff were not fully up to date with training and had not always received supervision from a senior member of staff. The registered manager had acknowledged this and put plans in place to address these issues. At this inspection, the service was now meeting the regulation.

At this inspection, we found staff had completed mandatory training to update their knowledge and skills. Staff said they had the training and skills they required to meet people's needs. Comments included: "We do a lot of training, both theory and practical sessions" and "The training really helps me feel confident about things." Staff completed induction training when they first joined the home which included safeguarding, fire safety and moving & handling. Staff were also expected to undertake refresher training to ensure their knowledge and skills remained up to date. New staff were supported to complete an induction programme before working on their own. Where they had not worked in a care setting before, they were expected to complete the nationally recognised Care Certificate. The Care Certificate was developed by Skills for Care. It is a set of 15 standards all new staff in care settings are expected to complete during their induction.

People were supported by staff who had supervisions (one to one meetings) with a senior member of staff. Staff said supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Records confirmed staff had received supervision in the last three months. The registered manager said that they, and their deputy, also worked alongside staff on occasions and gave feedback to them about their practice. This meant there were systems in place to monitor staff performance and identify good practice as well as any areas where improvements were needed.

People and their relatives were very positive about the skills and caring nature of staff. Comments included "Staff are very good" and "Staff are great, they really know what they are doing."

Staff said communication within the home was effective. For example, one member of staff said "when we come on duty we get a hand over which gives us information about each person."

Care plans contained up-to-date information about people's risks, needs and preferences as well as what staff needed to do to meet these. They also provided information about people's capacity to make decisions in line with the requirements of the Mental Capacity Act 2005 (MCA).

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person

of their liberty were being met. Although ten applications for DoLS had been made to the local authority, at the time of inspection none of these had been authorised.

At this inspection, we found staff had received training in the MCA and had an understanding of the Act. They were able to describe how to work with people, being mindful of the need to be as least restrictive as possible. For example one member of staff described how a person, who had been assessed as not able to go out safely on their own, had become agitated on an occasion. In order to support the person, the member of staff had accompanied them to go out for a walk. The member of staff had kept in phone contact with the home. This meant they had been able to also arrange for the person and themselves to be picked up at the end of the walk. This had enabled the person to go where they wanted to go which had helped them to become calmer.

Staff described how some people may not be able to make some decisions for example a major decision such as where they wanted to live. However they said the same people would able to make some choices about day to day decisions, for example what they wanted to wear or eat. Staff described how a person's capacity to make a decision might be affected by infections. They explained the actions they would take if they had a concern about a person. This included seeing if the person had an infection, alerting senior staff and making a referral to the person's GP. This showed that staff were working to support people to be as independent as possible whilst also recognising the support they needed for some issues.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

The staff were aware of people's dietary needs and preferences. For example, staff described how one person had an allergy to particular food and another person needed support when feeding. The cook was also aware of people's likes and dislikes and ensured there were alternative options for people at mealtimes. People told us they liked the food and were able to make choices about what they had to eat. For example, on one of the inspection days, a main meal of salmon with hollandaise sauce was served with potatoes and vegetables. Some people preferred to have chicken or a ham salad. There was also a choice of homemade puddings for dessert.

People were given a choice about where they ate their meals. For example, some people chose to eat in their bedroom while others chose to come to the dining room for their lunch. There were plenty of staff to support people at meal-times. For example on one of the inspection days, we observed at least five staff in the dining room throughout the lunchtime. Dining room tables were well spaced to allow easy movement between them and were laid up with tablecloths and flowers. Some people needed help with feeding. Staff sat beside them, making good eye contact and encouraging them to eat without rushing.

People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. Where one person said they did not want their main meal, staff offered them alternatives including sandwiches. However, the person said they were happy not to have anything other than the dessert.

People were referred appropriately to the dietitian and speech and language therapists if staff had concerns about their wellbeing. For example when their weight altered or if their ability to swallow was a concern.

People had access to health and social care professionals. Records confirmed people had appointments with their GP, dentist and an optician. Where concerns about a person's health and wellbeing were identified, staff contacted a relevant health professional to get advice and guidance.

The home had been adapted to provide an environment for people living there. A lift was installed which allowed people to have wheelchair access to both upstairs and downstairs areas. There were four lounges which people could use. While some lounge areas had a television, other areas were quieter. This meant people were able to meet friends and relatives in private if they wished.

Corridor areas were kept clear so people could move around the home more easily. The home was light and well-maintained. There were spaces for people to use, both indoor and outdoor including a large patio at the rear of the home and an outside balcony at the front. There was a grassed garden also at the front of the home with a summerhouse for people to use if they wished. People had been involved in the choice of decoration in their room and were able to bring items including pictures and ornaments to personalise the space.

Good

Is the service well-led?

Our findings

The home's website stated that Rest Haven was founded as an interdenominational Christian Home and was a registered charity. It described its aims as 'to provide accommodation for 34 male or female people aged over 65, regardless of their individual means.' Trustees, the registered manager and staff reflected these aims and promoted a caring environment which promoted people's physical, emotional and spiritual well-being. Although the home supported people to attend faith services, there was not a requirement for people to be of faith or to get involved in the religious aspects if they chose not to.

Voluntary trustees were responsible for overseeing the management of the home. Day to day management of the home was provided by a manager who had registered with the Care Quality Commission (CQC) in 2011. They were supported by a deputy manager and a senior staff team. Trustees visited the home at least weekly and undertook a monthly quality assurance check, which included talking to people, checks on staffing and walking around the building. They produced written feedback to the registered manager about these visits to support them to make improvements where needed.

An external health and safety consultant undertook an annual review of the buildings and equipment and fed back a written report to the registered manager. The last report, following an inspection in March 2017, had identified some actions which needed to be addressed to reduce the risks to people, visitors and staff. The report gave a priority level for how quickly improvements should be carried out, based on a risk assessment. For example a grade 1 risk required immediate action, a grade 3 risk recommended action within 2 months and a grade 6 (the lowest) required a yearly review or when circumstances changed. Although some actions had been completed, other actions, which should have addressed in line with the consultant's recommendations of one or two months, had not been fully completed.

This included actions relating to the rear garden, which stated 'a suitably secure handrail where you have sets of steps in the rear garden and a handrail or other barrier where there is a drop between the two paths as described, to prevent falls. Regularly clean off the metal stairs and landings to remove the lichen /algae build up'. We discussed this with the manager. They said, and our observations confirmed, they had undertaken actions to address the handrail where there were steps in the area used by the people living in the home. The external fire escape steps which led to staff quarters had also been cleaned. However they said they had not taken into account the other steps leading to an area of garden which was normally only used by staff. Following the incident where a person was injured whilst outside, the registered manager and the Trustee chairman undertook immediate action to reduce the risk of recurrence. They also developed longer term plans to improve the safety of other outside areas. The registered manager also agreed to ensure to complete any other actions to address outstanding issues identified in the report.
Audits were undertaken to ensure that the home was kept safe. These included internal audits of medicines, fire equipment, water temperature, legionella checks, electrical goods and general maintenance. Some audits were delegated to staff who then provided information to the registered manager about any issues identified. Where issues were found, there was evidence that remedial action was taken to improve.

Incidents and accidents were reviewed by the registered manager to consider where risks to people could

be reduced. For example, work had been undertaken to review information about when and where people fell.

The Chairman of Trustees worked with the registered manager to ensure the quality and safety of the home was addressed. The trustees met every six weeks formally and received quality assurance reports from the registered manager. Action plans were developed to address improvements needed.

There were regular staff meetings where staff were able to discuss issues and make improvements. Staff were aware of how they could raise concerns and said they believed the registered manager would take action. There was evidence that the registered manager had taken appropriate action in relation to a staff issue.

The service promoted a positive culture where people and their families were encouraged to get involved in ways to improve the service. This included holding resident and family meetings as well as having an "open door" policy for people to be able to talk with the registered manager and her deputy at any time. Thank you cards from relatives included comments such as "Made last Sunday such a real treat…[including] a lovely buffet" and "All the care, attention and kindness extended by you and all your wonderful staff…so impressed by the care, friendliness and attention to the welfare of each resident." The registered manager valued feedback and undertook surveys of people, their families and visiting professionals to get an understanding of how ty could improve the service.
People and their relatives knew both the registered manager and deputy manager well. One person came into the office to thank them for organising a change in their bed so quickly. They were very pleased about how efficiently it had been done as well as the result. Relatives were very positive about their leadership, saying "[Registered manager name], [deputy name] are always very approachable." Another relative described them, and staff as "…so kind, always welcoming. We can have lunch if we want."
The registered manager and her deputy regularly worked alongside staff which gave them an insight into how staff worked with people. Staff were observed referring to the registered manager and the deputy for advice and guidance.

The service has a positive culture that is person-centred, open, inclusive and empowering. It has a well-developed understanding of equality, diversity and human rights and put these into practice.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. However we discussed with the registered manager about reporting potential safeguarding incidents, which they agreed in future to do.

The registered manager had made links with the local community This included other care homes as well as local church and voluntary organisations. This meant that people were supported to remain connected with and feel part of the local community.