The Wilverley Association

Little Haven

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

Little Haven provides accommodation, personal care and nursing treatment for up to 43 older people. There were 39 people living in the home at the time of this inspection.

This inspection took place on 6 July 2017 and was unannounced.

At the last inspection on 3 and 4 February 2016 the service was rated Good. At this inspection we found the service remained Good.

This inspection was brought forward from the planned date due to concerns about how the registered provider was monitoring the safe management of medicines.

There were systems and processes in place to protect people from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to the management team.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Following concerns we had received since the last inspection, the medicines management procedures had recently been improved through increased monitoring and staff vigilance.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people in a patient and friendly manner.

Staff developed caring and positive relationships with people, were sensitive to their individual choices and treated them with dignity and respect. People and their families were supported to express their views and be involved in making decisions about their care and support.

The service was responsive to people's needs and staff listened to what they said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People were confident that any concerns or complaints they raised would be dealt with.

People living in the home and staff spoke positively about how the service was managed. There was an open and inclusive culture within the service. There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate care and support.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service was well led and continued to develop and make improvements.	**Good**

Little Haven

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 checked 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 was a comprehensive inspection that took place unannounced on 6 July 2017 and was carried out by one inspector accompanied by a specialist advisor and an expert by experience. The specialist advisor had clinical and practical experience and knowledge of best practice relating to the care of older people and those living with dementia. The expert by experience had personal experience of caring for someone who uses this type of care service.

Before we visited the home we checked the information that we held about the service and the service provider, including previous inspection reports and notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with eight people using the service and two relatives. We observed care and support being delivered in communal areas of the home to help us understand the experience of people who could not talk with us. We spoke with the registered manager and seven members of the nursing and care staff.

We looked at a range of documents and written records including seven people's care records, risk assessments and medicine charts, staff recruitment, rotas and training records. We also looked at information regarding the arrangements for managing complaints and monitoring the quality of the service provided within the home.

Good

Is the service safe?

Our findings

This inspection was brought forward from the planned date due to concerns about how the registered provider was monitoring the safe management of medicines.

There were procedures and records in place for the safe management of medicines and staff demonstrated a clear knowledge and understanding of the processes. The medicines room and trolleys were clean and tidy and these and fridge temperatures were checked regularly and records kept. Medicines administration records (MAR) were audited on a daily basis to ensure medicines had been given and signed for by staff.

The controlled drugs (CD) record book was clear and legible. Entries were double signed and correct numbers were recorded in the total column. Records showed CD's were given as prescribed. Pain charts were used to support staff to know if a person's pain was improving or getting worse. Protocols for medicines taken on an "as required basis" (PRN) were used for those people requiring them, including clear instruction as to what, when and why it could be given. There was a disposal process for unused medicines and products for disposal were recorded and stored safely.

Registered nurses explained how the systems of medicines management had improved through increased monitoring and actions taken following a number of errors by staff. A more robust system of checks included monitoring of correct doses, maximum doses, minimum intervals, omissions and the correct coding on records. Any errors/omissions were recorded on a form as an error or near miss regardless of whether the omission could be rectified immediately. All new staff had their medicines competencies assessed both through observation by senior staff and an online assessment before being able to administer medicines. If a member of staff was identified as making a medicines error, they were required to complete both assessments again, in order to support learning and safe practice.

People told us they felt safe living at the home and had no concerns. Their comments included: "I feel very safe here. They have nurses that stay through the night"; and "I am really safe here. There is always someone around to help me". A relative said "This place always has someone around to help her".

Risks to people had been identified, assessed and actions had been taken to minimise the risks, such as the risks of people falling, becoming malnourished or developing pressure wounds. This information was recorded in each person's care records and updated regularly with any changes to the level of risk or changes to health. Staff were aware of the risk assessment and management plans in place for people. Staff acknowledged that some risks to health and wellbeing needed to be accepted and taken, in order to promote and not limit people's freedom and independence.

People and/or their relatives were involved in decisions about risks. A relative told us "We have had discussions with someone about the risks regarding things like falls. Another relative confirmed they had discussions with staff "About how best to help keep her safe". We asked people if they were able to do the things they would like to do. Their comments included: "Yes I can, no one will stop me doing anything"; and "Yes of course I can. No one says you can't do this or that".

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They knew how to report any suspicion of abuse to the management team and external agencies, such as the local authority safeguarding team, so that people in their care were protected and their rights upheld. Policies were in place in relation to safeguarding and whistleblowing procedures and these were accessible to all staff. Records showed and staff confirmed that they had received training in safeguarding adults as part of their training and this was regularly updated.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Regular fire alarm tests and drills were carried out and staff attended relevant training. Equipment was checked and serviced at regular intervals.

The provider and registered manager kept staff numbers under review. A dependency tool was used to evaluate staffing requirements based on people's changing needs and levels were adjusted accordingly. A registered nurse said they felt staffing had improved and that the team was settled. Regular agency staff were used to provide continuity of care and a new permanent night nurse was starting work soon. Another registered nurse also told us staffing numbers were now much better and the care staff were very competent and caring. A care worker said "We're managing our workload very well at the moment".

People's comments confirmed there were sufficient staff deployed to meet their needs. For example: "I think there are enough for me"; "I don't have issues with getting hold of someone"; "Possibly do with one or two more. I don't have any problems finding someone to help me"; and "They could probably do with a few more but I have no complaints. I am well fed and taken care of". A relative told us "I think they can do with more staff, but they ones they have are really good".

The provider had continued to assess the suitability and character of staff before they commenced employment. We looked at the records of two care staff and two registered nurses who had all been recruited since the last inspection. Records included previous employment references and Disclosure and Barring Service (DBS) checks. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk. Records were on file showing that checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register. The system of checks included profiles of agency staff who worked at the service.

The home environment was clean and we observed that staff were aware of infection control procedures. Barrier nursing precautions were in place for one person and there was clear signage on their bedroom door. Personal protective clothing such as gloves and aprons were available outside of the room and used appropriately by staff. Sluice rooms were clean, tidy and well organised and doors were locked when not in use.

Good

Is the service effective?

Our findings

People told us they were confident in the skills of the staff who supported them. Their comments included: "Very confident. I have never had a time when I asked them something and they didn't know what was going on"; "They always know what they are doing"; "I can't complain, they are good at their jobs"; "They understand what I need"; and, "They are very skilled. I don't know, they just take the time to make sure I am alright". A relative told us "I have to say from everything I have seen of them they are doing a really good job. They are attentive and hardworking. I have nothing to complain about". Another relative said, "I can ask any of them any questions and they will try their best to answer me or find out what is happening".

New care staff undertook a period of induction and shadowing experienced staff before they were assessed as competent to work on their own. The induction incorporated the Care Certificate, where appropriate, which is designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that are expected to be upheld. Staff were further supported through on-going training and regular supervision and appraisal meetings. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Care staff were also supported to undertake vocational qualifications in care. One care worker had enrolled on a leadership and management course in order to further their professional development.

Two nurses said they had supervision with the registered manager three or four times a year and had completed an annual appraisal. They told us training was, "Excellent and thorough". They had received all the training they had requested and nearly all nurses were now competent in phlebotomy and catheterisation, which meant they were able to respond quickly without calling in outside agencies for support in these areas. One of the provider's senior managers carried out in-house training and there was also regular external training and online modules.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

A care worker told us they had recently completed MCA training that included assessment scenarios and role play, which they found very useful in furthering their understanding. They said "We have people who lack capacity but that doesn't mean they can't make choices; and people who have capacity but sometimes need help making choices". They spoke about the five principles of the MCA. For example, respecting a person's right to make decisions, even if these appeared to be unwise choices, by "Supporting the person and informing them about the consequences; empowering them".

People confirmed that staff sought their consent before providing care. For example, "If I say no they understand it means no"; "Yes they do (ask). I have never had any issues with them listening to what I say and going along with it. If I don't want a shower in the morning they won't force it on me"; and "They don't

force you into doing anything". Care plans contained evidence of people being asked for their consent to their photographs being on file and external agencies having access to their care records if appropriate. A capacity assessment tool was used to record and evidence the reasons for any decisions that were made in a person's best interests.

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). The registered manager had made the appropriate DoLS applications for people using the service.

People were effectively supported to eat and drink enough to meet their needs. Care plans included nutritional assessments and details of people's dietary requirements and support needs. A risk assessment tool was used to help identify anyone who might be at risk of malnutrition and specific care plans were in place to minimise this risk. Plans also incorporated speech and language therapist (SALT) assessments.

At lunch time staff offered each person on arrival a seat and a choice of drinks including sherry, juice or water. The menu offered a choice of meals and people were also given menus and support if required to choose the next meal. People using wheelchairs or other specialist chairs were pushed to the table and included in the mealtime experience if they wished. The atmosphere was calm and relaxed with warm and positive interaction from staff who provided appropriate support as and when required. People we spoke with told us they enjoyed meal times at the home.

During lunch time we observed that staff were attentive and patient and people received support when needed whether eating in their rooms or the dining area. There were sufficient staff to help with assisting people to eat and there was an effective use of teamwork, which meant people received their meals and any support they required in a way that was both timely and unhurried. The meals were brought out in a trolley with each person's name on it. Staff gave people their lunches, offered to cut the food and asked if they would like another drink before moving on. All the care staff knew each person's name. Three staff sat to help people with their meals. They sat at a 90 degree angle from them and spoke with the person letting them know what they were doing.

People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, occupational therapists, opticians and dentistry. Two nursing staff spoke about improvements in communication within the team and said there were a number of communication tools that were now in place and working well. These included, for example, a bloods and appointments folder, identifying who required appointments and when these had taken place; and a GP folder regarding booked appointments and a summary of outcomes.

Good

Is the service caring?

Our findings

People were positive in their comments about the care they received and throughout our inspection, we found examples of a culture of personalised care being promoted by the managers and staff.

People told us the staff were caring and compassionate, for example showing concern for them if they were worried or upset about something. Their comments included: "That is one of the things they are really good at. They really do seem to care"; "I wasn't feeling well the other day and one of carers sat with me for a long time. I really like that they do that"; "The staff are always happy here, and that makes me happier"; and "Yes, they are always smiling and I have never seen them complain about anything ever".

A relative said "If she is unwell, the staff do take the time to look after her and make sure all her needs are met. I have no worries that they are doing the best they can". Another relative told us "There are times when I come around and the staff are sitting with her because she was upset. I think they really do try their best".

Staff developed positive caring relationships, being respectful and courteous towards each other and people living in the home. Staff were kind, helpful and friendly and appeared to be happy in their work. A care worker told us "A lot of the girls came in on their days off to help out (on Red Nose Day). We had such good fun". Further comments from people about the caring approach of staff were: "They will always come around and say are you ok, do you want a cup of tea, is there anything else I can get you?"; "They are very caring towards me. They drop by ask me if I need anything else. I am really happy with them"; and "I think they really care for me. Anything I need they will try and do it. Yes, they will listen to me".

People confirmed that staff treated them with respect and provided care in ways that upheld their dignity. Their comments included: "Yes they do. Things like they close the door when I am getting changed"; "They will cover me up when I am having a shower. They also don't talk about personal things in front of my friends"; "The way they talk to you, they are always respectful"; and "I have never paid it any attention to be honest. I guess they do". A relative told us "Yes, just the little things. If they want to have a chat, we will have it in private and not out in the open. If they need to change her they will ask me to leave".

People were supported to express their views and be involved in making decisions about their care. The registered manager facilitated residents meetings every six weeks. Once a month each person became 'resident of the day', during which all aspects of their care and support was reviewed with them by staff from the various departments within the home, including catering for example. People were informed when this was due to take place so they could invite their relatives if they wished. Alternatively the date could be re-arranged.

People's end of life care wishes, where they had agreed to discuss these, and any advance decisions were documented in their care plans and kept under review. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate. Staff told us the home had a good working relationship with a hospice and utilised their expertise and support.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs and any concerns they had. People told us that the managers and staff spoke with them about the care and support provided, listened to what they said and respected their views. A person commented "We had a meeting earlier this year. We discussed the things that had changed and if I needed something". Another person confirmed "We had a proper meeting once this year. My children were around and we spoke to I think the manager. They really do listen and try and help out". Other people's comments were "I don't think we have had an official discussion about it. But I can talk to the carers about what I need"; "If I need something I can just ask them whenever I like"; and "They always ask if there is anything else I need or want done".

A relative said "I think we have meetings twice a year. I am happy with the way they handle things. Yes, they do listen to our views and talk about how best to help us". Another relative told us "Every four or five months we have a sit down and discuss what is going on. I am happy with the service they provide us".

People's needs were reviewed regularly and as required. Where necessary external health and social care professionals were involved. Before people moved into the home they and their families participated in an assessment of their needs to ensure the service was suitable for them. Involving people and their relatives in the assessment helped to make sure that care was planned around people's individual care preferences.

The care plans had recently been totally rewritten and restructured. A registered nurse told us there had been "A massive change in the care files" and this had "Improved working, communication and care". Another registered nurse said the changes to the style and structure of care records had reduced numerous duplications and "Documentation for documentations sake". They told us "Resident of the day works really well", enabling all staff to know residents better and making the task of reviewing and completing the documentation less arduous. They said care plans were being updated more meaningfully and robustly.

We reviewed the care records of seven people. The plans were written in a clear, accessible style and provided insight into each person and their needs. For example, a person's communication care plan included placing the call bell in their right hand due to a medical condition causing a weakness in their left side. Staff had a good knowledge and understanding of each person and their needs and started recording relevant information from the first day of admission.

One person occasionally showed verbal and physical aggression towards staff. A risk assessment and care plan gave clear information about what happens, why it may happen and how to support the person. Staff worked in pairs when offering personal care and used a behaviour chart to try to identify any factors that may trigger the behaviours. The care plan had been adapted to reflect the changes in the person's support needs and was regularly reviewed. Incidents were recorded and reported and a referral had been made to the community mental health team for specialist support.

There were systematic procedures that staff followed in relation to wound care management. This included the use of a specific assessment tool to monitor and identify any risk to skin integrity so that preventative

action could be taken. A wound tracker folder was held in the nurses' office and showed when wound dressings were due to be changed and when they were completed. This was also noted in the nurse office diary. By tracking through a person's records and speaking with staff, it was evident that the staff had communicated well, identified a change in the person's wound and physical symptoms and liaised with other health professionals in providing appropriate treatment.

Handover between staff at the start of each shift helped to ensure that important information was shared, acted upon where necessary and recorded. We observed a staff handover between the morning and afternoon shifts. The discussion between staff was informative, clear and comprehensive and demonstrated a person centred approach. A registered nurse asked staff to be mindful of not putting a person's hair in a pigtail to the left where a dressing was, although the person usually had it this side, as her hair was getting stuck on the dressing edges. There was also a lot of discussion about supporting people to make choices. This helped to ensure that people's needs were met in a responsive manner.

There was an activities notice board and calendar that included communion in the garden, Tai Chi, movement to music, coffee mornings, morning news on large screen TV, bingo, singing/entertainers, yoga, and residents meetings. A notice had been put up informing people that a coach would be laid on if they wished to attend a former resident's funeral.

People told us: "We have a folder here with the list of things they are doing each day. I can take part in any of them"; "They always have things going on. I think today they have some music thing going on. I will go to it"; and "I have friends in here that I sit around and talk or I watch a bit television. They also have activities here that I do". A relative said "I know they have a lot of games and activities going on in here but I don't know exactly what they do. We do go (to activities), especially now that the weather is nice. If anything it encourages us to do things".

In the afternoon a singer came in to entertain people in the lounge. Two care staff moved among the twelve people in the room, sitting with them and encouraging some of them to join in. The activities coordinator offered one to one activities to people who preferred to not take part in group activities.

The service had systems in place in order to listen and learn from people's experiences of care. A satisfaction survey was carried out that included questionnaires. The responses showed that people felt staff always treated them with dignity, respect, kindness and compassion. Respondents had rated the overall quality of service provided as either good, very good or excellent. A report and action plan had been written in response to themes raised by the survey results, such as reducing the use of agency staff and increasing involvement with the local community, and this had been shared with people living in the home.

People we spoke with had not had any reason to complain about the service and were confident about approaching the managers and staff about any concerns they may have. A system and procedure was in place to record and respond to any concerns or complaints that were received about the service. The complaints log showed that the registered manager had listened and taken action when a complaint or concern was raised. A complaints and compliments book was also available in the reception area. Senior staff read and, where appropriate, replied to comments. For example, where a relative had commented that a person's nails needed cutting, a response was recorded showing action had been taken. There were also many complimentary comments in the book.

Good

Is the service well-led?

Our findings

The service 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's comments confirmed there was an open and transparent culture within the service. For example: "If a problem does occur they are pretty good at saying this is what has happened and we are going to change it"; "Yes, they will tell me anything that has happened"; and "They are open in the sense they talk about everything with me". A relative told us "I think they are pretty good at being open and fair".

People told us the staff and management communicated with them about what was happening within the home. A number of people told us "Each week we get a folder with all the information about the things going on". One person said "I usually just talk to the staff and one of them will tell me what is going to happen today". A relative told us "I really like the staff and the way they communicate with me. They always let me know what is going on".

A registered nurse said they felt the management staff were supportive and approachable and the registered manager was quick to act on incident reports, feedback and investigation. Another registered nurse told us they were well supported and described the management team as "fantastic, the best employers". They said the registered manager was very visible, approachable and "A fab leader". Care workers also spoke highly of the registered manager. One told us "I can talk about anything, there are no silly questions". Another care worker said they felt the service was well run. "I'm happy to come to work," and "I feel able to go to management to ask for help and don't feel awkward". They said staff meetings were held on a monthly basis and the registered manager "Listens and acts on staff requests".

Regular audits of the quality and safety of the service took place and were recorded. For example, there were audits of care plans, medicines, infection prevention and control and incident reporting. The outcomes of resident and staff survey questionnaires were analysed by the provider and management team and the responses were fed back. The registered manager completed monthly reports on how the service was performing, including information relating to any medicines errors, pressure wound care, accidents and incidents, safeguarding referrals and complaints. This data informed clinical governance meetings and a summary report with actions and recommendations was sent to the Board of Trustees. The service had systems in place to report, investigate and learn from accidents and incidents. Records showed that investigations were undertaken following concerns or incidents and that appropriate actions were taken in response.

In April 2017 we had received concerns from a partner agency in relation to medicines errors and how medicines management was monitored within the home. The registered manager had identified there were errors and reported their findings. Following this, the provider and registered manager informed us of the outcome of their investigation. Actions that were taken to improve the safe management of medicines

included weekly audits and daily cross checking, further training and medicines competency assessments of relevant staff, analysis of errors, and a staff group reflective session in order to learn from and address the issues. The registered manager reported that these measures had resulted in a significant reduction in overall errors.

There were clear lines of accountability within the service. The registered manager was supported within the home by a care team led by two clinical lead registered nurses who managed the registered nursing team and two associate practitioners who managed the team of health care assistants. Registered nursing and care staff were professional, knowledgeable and engaging. Staff were smartly dressed and wore visible name badges. Staff had a clear understanding of their roles and responsibilities and demonstrated passion and commitment in their work.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the home and on the provider's website.