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Haven Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 22 and 30 November 2017. The inspection was unannounced. Haven Lodge 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. Haven Lodge accommodates up to 12 people in one building. On the day of our inspection 12 people were using the service.

At the last inspection in August 2016, we asked the provider to take action to make improvements to the safety of the service, leadership and quality assurance. During this inspection we found the required improvements had not been made.

The service is operated by an individual and so does not require a registered manager. The registered provider is the 'registered person.' 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. The registered provider had employed a manager who supervised the day to day running of the service.

During this inspection we found the service was not safe. Environmental risks were not consistently identified or addressed, consequently people were exposed to the risk of serious harm. People were not always protected from risks associated with their care and support. Action had not been taken to protect people from the behaviour of others living at the home. Systems to review and learn from accidents and incidents were not consistently effective and this meant we could not be assured that action was taken to protect people from harm. Action was not always taken to protect people from improper treatment or abuse. There were a number of safeguarding investigations underway at the time of our inspection visit.

Medicines were not stored or managed safely. There were enough staff to provide care and support to people when they needed it. However, safe recruitment practices were not followed.

Where people lacked capacity to make choices and decisions, their rights under the Mental Capacity Act (2005) were not always respected. Staff felt supported, but did not receive sufficient training to enable them to effectively meet people's individual needs. People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions, as support plans did not contain enough information. People were supported to have enough to eat and drink, however choices were limited.

People did not always receive person centred support which met their needs. Staff had a limited understanding of how to support people with mental health needs and this resulted in people not receiving appropriate support. People were subject to institutionalised practices. Policies and practices were not person centred. Staff respected people's privacy.

People were at risk of receiving inconsistent support as care plans did not provide an accurate or up to date

description of people's needs. People's feedback about opportunities provided by the service was mixed and we found there were limited opportunities for meaningful activity. People knew how raise issues and concerns, however some people did not feel comfortable doing so.

The service was not well led. Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of serious harm. There were no systems in place to record, analyse and investigate incidents which posed a risk to the health and wellbeing of people who used the service. Swift action was not always taken in response to known issues. Staff felt supported and were able to express their views in relation to how the service was run.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from risks associated with the environment or their care and support. People were placed at risk of serious harm.

People were not protected from improper treatment or abuse.

Medicines were not stored or managed safely.

There were enough staff to provide care and support to people when they needed it. However, safe recruitment practices were not followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions.

Staff did not receive sufficient training to enable them to effectively meet people's individual needs. Staff were provided with regular supervision and support.

People were supported to have enough to eat and drink. However, choice was limited.

Is the service caring?

Requires Improvement

The service was not caring.

People did not always receive appropriate support which met their needs.

People were subject to institutionalised practices. Policies and practices were not person centred.

Staff respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a risk people may receive inconsistent support as support plans did not always contain adequate information to inform support.

There were limited opportunities for meaningful activity.

People knew how raise issues and concerns, however they did not always feel comfortable doing so.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective and this resulted in poor outcomes for people living at the home.

Appropriate action was not taken to analyse and investigate incidents which posed a risk to the health and wellbeing of people who used the service.

Swift action was not always taken in response to known issues.

There were no systems in place to keep up to date with good practice.

Haven Lodge

Detailed findings

Background to this inspection

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

We inspected the service on 22 and 30 November 2017. The inspection was unannounced. The inspection team consisted of three inspectors.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. 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 used this information to help us to plan the inspection.

During our inspection visit we spoke with six people who lived at the service. We also spoke with two members of care staff, the manager and the provider.

To help us assess how people's care needs were being met we reviewed all or part of six people's care records and other information, for example their risk assessments. We also looked the medicines records of five people, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out general observations of care and support looked at the interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

During our previous inspections in May 2016 and August 2016 we found concerns about how risks associated with the environment were managed. At our inspection in August 2016 this resulted in a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, risks associated with the environment were still not identified or addressed. This resulted in a failure to safely manage significant risks and exposed people to the risk of harm.

People were not protected from the risk of scalding. We found water temperatures were above the Health and Safety Executive (HSE) recommendations of 44°C for health and social care settings, this exposed people to the risk of scalding. One shower measured in excess of 70°C. There were no risk assessments in place which meant no assessment of potential scalding risks, taking into account people's impairments, had been conducted. We wrote to the provider and asked them to take urgent action to resolve this issue. The provider informed us the shower had been turned off. However, at our inspection on 30 November 2017 we found the shower had not been effectively taken out of use, we were able to turn it on and the temperature measured 65°C. This did not assure us the provider had taken all reasonable steps to reduce the risk and this placed people at continued risk of serious harm.

People were not protected from the risk of sustaining burns from hot surfaces. The HSE states 'contact with surfaces above 43 °C can lead to serious injury'. We found heaters and radiators did not have suitable covering and there were no risk assessments in place. One person had their bed pushed up against a large exposed radiator. They were at risk of seizures so this placed them at significant risk of sustaining burns from the radiator should they have a seizure whilst in bed. Another person, who had reduced mobility and limited mental capacity to ensure their own safety was left alone in their room with a large exposed storage heater. The surface of the heater was significantly above the recommended level. This failure to identify, assess and mitigate risk placed people at risk of serious harm. We wrote to the provider and asked them to take urgent action to address this risk. During our inspection on 30 November 2017 action was underway to cover radiators. However, it remains of concern that this serious risk had not been identified prior to our inspection.

People were not protected from the risk of falling from heights. Windows on the first floor were not restricted and consequently opened far enough to allow a person's body to pass through. Some people living on the first floor had reduced mental capacity and / or significant mental health needs which may have impaired their judgement or ability to keep themselves safe. There were no risk assessments in place in relation to falling from windows. One person had a mental health condition and was regularly intoxicated. The window in their bedroom was not restricted. The failure to consider the risks posed by windows placed people at risk of serious harm. We wrote to the provider and asked them to take urgent action to address this risk. During our visit on 30 November 2017 we saw action had been taken to restrict windows. However, it remains of concern that this serious risk had not been identified prior to our inspection.

People were not adequately protected from the risk of fire. We identified a number of concerns about the management of fire risk. The fire risk assessment stated smoking was only allowed in the 'snug' (a small

room on the ground floor). Despite this, we found evidence of two people smoking in their bedrooms, including cigarette ends and burns to flooring. Assessments of the risk of people smoking in their rooms had not always been conducted, and when they had, control measures were not sufficient to reduce the risk of fire. This posed a serious risk to the health and safety of people living at the home and staff.

We found areas of the building which increased the risk of fire, or that posed a risk in the event of a fire. The boiler was situated in the basement, there was a sign displayed which stated 'flammable items must not be placed on top of the boiler'. Despite this, we observed combustible items directly on top of the boiler. Furthermore, the basement area was cluttered with other combustible items which could facilitate the spread of fire. Some fire exit routes were restricted. The first floor exit route had a chain across it. This was not specified in the fire risk assessment and consequently no measures were in place to ensure its swift removal in the event of a fire.

Personal emergency evacuation plans (PEEP) were only in place for two of the 12 people living at Haven Lodge. This meant there was a risk people may not get the support they required to exit the building in the event of a fire. Following our inspection we notified the Fire Service and asked the provider to take urgent action to mitigate the fire risks we identified. The provider took action to reduce the risks to people; however, it remains of concern that these risks had not been assessed prior to our inspection.

People were not always protected from risks associated with their care and support. Risks were not consistently identified, assessed or managed. Records showed one person had recently had seizures. Although there was a risk assessment in place, the only control measure to ensure their safety was hourly checks when they were in their room. This posed a risk the person may have a seizure and not be found for up to an hour which placed them at risk of harm. We wrote to the provider and asked them to take urgent action to reduce the risk. They informed us they had purchased some assistive technology to address the risk. However, they had not sought specialist advice about the potential effectiveness of the technology. This meant we could not be assured it would effectively mitigate the risk.

People were not protected from risks arising from the behaviour of others living at the home. One person had a recent history of aggression towards others. Despite this, there was no risk assessment in place in relation to the risk posed to others. Staff explained the person was directed to their room when their behaviour escalated. There was no evidence that any consideration had been given to immediate action required to protect people in the event the person did not comply with this request. We wrote to the provider and asked them to take urgent action. The provider informed us there had been no incidents of aggression towards others. Consequently no additional contingency measures were put in place. During our inspection visit on 30 November 2017 we found evidence the person had behaved in a threatening way towards other people who used the service causing them distress. This failure to safely manage people's behaviour placed people at risk of psychological distress or physical harm.

Medicines were not managed safely. Risks associated with people administering their own medicines had not been assessed or managed. One person managed their own medicines but the risks this posed to them and others had not been assessed. The person had been provided with secure storage for their medicines but we observed that this was not in use and staff did not conduct any checks. This meant there was a risk that other people may have been able to access the medicines. Furthermore, the person's care plan stated there was a risk they may stop taking medicines. Despite this, there were no checks in place to ensure they had taken their medicines. This placed them at risk of not having their medicines as required. We wrote to the provider and asked them to take urgent action to address this. During our inspection on 30 November 2017 we found checks on the storage of medicines were still not robust. The manager told us they were unable to check if the person had taken their medicines as they were disorganized and they did not know

how much medicine should be in stock. This failure to implement effective systems to support the self-administration of medicines placed people at risk of harm.

Medicines were not stored safely. We found a bottle of unidentifiable medicine stored in the medicines trolley. The pharmacy label was covered by a handwritten label, which did not state what the medicine was, the dosage or who it was prescribed to. This meant staff would be unable to identify who the medicine belonged to or what medicine it was. Furthermore, the medicine was not recorded on medicines records, which meant we were unable to determine how much should be in stock. This failure to ensure the safe labelling and storage of medicines placed people at risk of not receiving their medicines correctly.

People did not always receive their medicines as required. Medicine records showed delays to the supply of some medicines and this resulted in people not getting medicines as prescribed. One person was prescribed pain relief on an 'as required' basis. Medicines records showed the person routinely took the medicine two or three times a day. The medicine went out of stock the day prior to our inspection and consequently on the day of our inspection the person had not had any painkillers. This failure to ensure sufficient supply of medicines placed the person at risk of experiencing unnecessary pain.

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no systems in place to record, review and investigate events relating to safety and safeguarding incidents and this meant action had not been taken to ensure people were protected from the risk of abuse or improper treatment. The provider had not taken appropriate action in response to incidents of a safeguarding nature. Records showed one person had been discharged from hospital with bruising. Although staff had sought support from the district nursing team, no action was taken to refer it to the local authority safeguarding adult's team to enable investigation of the cause of the bruising. Medicine records for another person showed they had recently missed the morning dose of all of their medicines for four consecutive days, including those prescribed to treat their mental health condition. The person's care plan documented this could lead to a deterioration in their mental health and during our inspection the provider informed us the person's behaviour had recently escalated. Despite this, the missed medicines had not been referred to the local authority safeguarding team. This meant we could not be assured people were protected from the risk of abuse or improper treatment.

We wrote to the provider and asked them to take urgent action to ensure incidents of a safeguarding nature were responded to appropriately. The provider told us they would make referrals in the future. Despite this, during our inspection on 30 November 2017 visit we identified a further safeguarding incident which had not been identified and consequently not reported to safeguarding. Records showed one person had suffered significant distress resulting from an incident involving another person who lived at the home. The provider had not taken any action to make the required safeguarding referral. This meant we could not be assured that people would be protected from abuse and improper treatment.

Prior to, and during the course of, our inspection, we received information of concern regarding discriminatory views and intimidation. We took action to refer this information to the local authority safeguarding adults team and these concerns remain under investigation at the time of writing this report.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate steps had not been taken to ensure people were protected from staff that may not be fit and safe

to support them, as safe recruitment processes were not always followed. Each of the four staff files we viewed were missing information. Staff files did not always contain sufficient information about the staff member's employment history. The recruitment file for one staff member did not contain their full employment history. There was no evidence the provider had identified or explored the gaps in their employment history. References obtained were not always sufficient. Another staff member only had one reference on file and it was unclear who had provided this. This meant we could not be assured of the validity of the reference. Furthermore, there was no proof of identification in this staff member's file and no proof of their eligibility to work in the UK. This meant that the provider did not have all the relevant information to make a decision about the suitability of staff employed at Haven Lodge. This placed people at risk of harm as a result of being supported by unsuitable staff.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection we found concerns about the cleanliness of the home and measures in place to prevent and control the spread of infection. During this inspection we found some improvements had been made in this area however further improvements were required. Overall the home was cleaner and there were audits in place to ensure the effective cleaning of bedrooms and communal areas. However, we found one person's bedroom had an unpleasant odour and the mattress had been penetrated with bodily fluid. We also found soap was not available at all basins to ensure effective handwashing practices. We raised our concerns with the provider and on the second day of our inspection we saw that these had been addressed.

People felt there were enough staff to meet their needs. They told us they did not need to wait for support and that there was always someone around when they needed them. We saw that most people using the service were very independent, but any requests for support were responded to swiftly. Staff told us that they felt there were enough staff to meet the needs of people who used the service. We reviewed staffing rotas which showed that shifts were staffed at the level determined by the provider as safe.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests. Whilst care plans contained some assessments of people's capacity, mental capacity assessments and best interest decisions were not always in place as required. Decisions made in people's best interests were not always clearly recorded. For example, one person's medicines were placed in their food. Records showed this person lacked the capacity to make a number of decisions about their care and support. However, there was no documentation in place to demonstrate that their capacity to make the decision about having their medicines placed in food had been assessed or that this was in their best interests. Staff told us they had to make some day to day decisions on behalf of another person living at Haven Lodge. Despite this there were no assessments of the person's capacity to make these decisions. This meant people's rights may not always be promoted as the provider was not always acting in accordance with the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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. The manager told us no DoLS applications had been made for anyone living at Haven Lodge. However, there was one person who lacked capacity to consent to restrictions on their freedom. The manager told us no DoLS application had been made for this person. This demonstrated the manager did not have an adequate understanding of DoLS and did not assure us that the necessary steps would be taken to ensure people's rights would be protected. We did not receive any assurances after the inspection that a DoLS application had been made.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Haven Lodge told us they felt staff had the required skills and competency to support them. Despite this positive feedback we found staff lacked training and skill in some areas.
Although records showed staff had training in a number of areas including safeguarding adults, first aid and the safe administration of medicines, there were key areas where staff lacked training. For example, although everyone living at the home had mental health needs staff had not any training in mental health. We found this had resulted in staff having a limited understanding of people's mental health needs. This meant staff did not always have the required knowledge or competency to ensure people received the support they required.

New staff were provided with an induction period when starting work at the service. The manager told us that staff induction included training and shadowing of more experienced staff. New staff had completed the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Staff told us that they felt supported and records showed they had received regular supervision.

Although we found that, on the whole, people had enough to eat and drink, their choices in relation to food and drink were limited. Records showed, and people told us, they were involved in deciding on the menu at Haven Lodge. They were positive about the quality of the food but told us they were not always given a choice of meal each day. We observed that the majority of food and snacks were stored in a locked pantry. This meant people were not able to freely access food between mealtimes as they had to ask staff. This was confirmed in our discussions with people living at the home who told us they could have snacks but they had to ask staff permission. We spoke with the manager about this and they did not provide a sufficient explanation of why snacks were kept in a locked room. Furthermore, we observed a notice on the fridge in the pantry entitled '[Person's name's] daily snack allowance'. This specified the amount of snack items the person was allowed each day. Although the manager told us they would be provided with more if requested, the person's care plan documented that they had capacity to make decisions in this area and it was therefore unclear why they had been allocated a 'snack allowance'. During our inspection we received concerns from a person living at the home that access to food was restricted and they were sometimes made to wait unnecessarily for food. We referred these concerns to the local authority safeguarding adults team and these remained under investigation at the time of writing this report.

Where people had been identified as being at risk of losing weight there were systems in place to monitor this and records showed action was taken if people lost significant amounts of weight. Staff had a good knowledge of people's dietary requirements. For example, one person using the service had been assessed as requiring a specific texture diet, staff were aware of this and we observed the person was served food in line with this requirement.

There was a risk that people may not receive the support they required with specific health conditions, as staff did not have access to sufficiently detailed information. For example, one person had dementia, despite this; their care plan contained no information about the impact of this on their health and wellbeing. Another person had a condition which caused them to have seizures, however their care plan did not contain sufficient information to inform staff support and consequently we found staff knowledge of the person's condition was limited. This lack of information placed people at risk of not receiving the support they required with their health.

Despite the above, people told us they received effective support in relation to their health. We saw records of contact with health professionals in people's support plans which showed that people were supported to access the GP as needed and other health professionals such as dentists and opticians. The manager told us they were responsive to people's changing health needs. They told us about one person who had recently had a hospital admission and was discharged form hospital with limited mobility. The staff team had worked with external health professionals to help the person regain their mobility. Another person had suffered a stroke, again the staff team had worked with health professionals to rehabilitate them and this had led to the person being able to continue living at Haven Lodge.

Haven Lodge is situated in a large Victorian terraced house. Some adaptations had been made to the physical environment to accommodate people's needs. For example, grab rails had been installed in communal areas to enable people with mobility needs to navigate around the building. The provider had also recently installed a new call bell system to ensure people could summon staff as required. There were

two communal areas which meant people had ample space to spend time with other people who used the service. We observed there was limited comfortable seating in the most frequently used communal area, which meant some people had to sit on dining chairs between meals if they wished to use this area. We spoke with two people living at the home who told us they thought extra seating would be beneficial. There was an internal smoking area and since our previous inspection, at the request of people living at the home, additional seating had been provided. People also had access to a large, garden and people told us this was used for events such as barbeques in the summer months.

Systems were in place to ensure information was shared across services when people moved between them. The manager told us they had recently implemented the 'red bag' scheme. This scheme is designed to share information and important items, such as medicines, between care homes and hospitals, to ensure care is person centred.

Requires Improvement

Is the service caring?

Our findings

The care and support provided at Haven Lodge was consistently not person centred and this resulted in people's rights not being respected.

The provider's approach to managing some people's mental health conditions was punitive and did not respect their rights. We identified concerns that people were subject to outdated, institutional practices and inappropriate measures were being used to punish incidents of aggression. Records showed and the manager confirmed, that one person had their television taken away as a punishment following a period of verbal aggression. The manager told us, "When [person] is rude we say to them 'no TV'. It is like a sanction." This form of behaviour control is not an appropriate technique for managing the behaviours of adults with complex mental health needs. We discussed this with the provider, who told us, "These people are like children, we need to deal with them somehow." This did not respect the rights of the adults living at Haven Lodge. Traditional views of disability and mental illness, institutionalised practices and inappropriate approaches intended to control behaviour exposed people to psychological harm and distress.

People were not always provided with appropriate support that promoted their acceptance and inclusion. Staff did not have a good understanding of the impact of people's mental health needs and consequently people were not provided with respectful, person centred or appropriate support. Training records showed staff did not have any specific training in mental health and staff we spoke with demonstrated little understanding of people mental health needs. We asked a staff member about common mental health conditions experienced by people living at Haven Lodge, they were unable to differentiate between conditions or describe associated symptoms. This lack of knowledge and skill had a negative impact on people living at the home. For example, one person had a mental health condition which sometimes led to them becoming distressed and shouting at voices they could hear in their head. Their care plan stated if this occurred staff must ask them to go to their room so they did not disturb others. There was no further information about how staff should support and reassure the person to ensure their mental health needs were met appropriately. This approach did not meet the person's needs, did not promote their recovery and neglected their need for care and support.

Policies and practices at Haven Lodge were not person centred. During the course of our inspection we observed, and received feedback about, institutional practices which had been implemented to suit the needs of the service. This did not ensure that people's individual choices and preferences were met. For example, people living at the home were not allowed in the kitchen when staff were preparing food and a chain was used across the door way to prevent them from entering. Practices such as this did not promote a culture of equality or promote people's independence. We were also made aware of institutionalised policies. For example, in response to one person trying to access the home late at night with friends who may have posed a risk to others, the provider had implemented a blanket policy which stated that people were not allowed to return to the home between 11pm and 7am. This did not respect the fact that Haven Lodge is people's home and placed people at risk of harm should they be unable to access their home at night.

We observed interactions between staff and people living at the home were functional and task focused. There were few conversations and communication was brief and functional. We discussed this with the manager and provider who told us this was due to the presence of the inspection team. However, during the course of our inspection we received information of concern regarding the approach of some staff at Haven Lodge. This included allegations that staff told people what to do and staff not treating people with dignity and respect. We took action to refer this information to Nottingham City Council Safeguarding Adults Team and these concerns remained under investigation at the time of writing this report.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a risk people may not be enabled to access an advocate should they need one to help them express their views. Advocates are trained professionals who support, enable and empower people to speak up. The manager told us people had been asked by their GP if they wanted an advocate but no one had taken up this offer. We did not observe any information about advocacy displayed in the service, therefore people were reliant upon staff to make them aware of advocacy services.

The manager told us no one living at Haven Lodge had any needs around accessing information. This was confirmed by our observations, although some people had sensory and cognitive impairments we saw they were able to access and understand mainstream media such as newspapers, television and radio.

Despite the above, we found some areas of person centred practice during our inspection. People's care plans contained information about their background and their preferences for care and support. Staff had a good knowledge of this and ensured people's preferences were met. For example, one person's care plan stated they liked their clothes warmed prior to dressing, staff told us about how they did this each day. Another person liked to keep up to date with events in their home country and we observed staff regularly bought them a newspaper from this country.

People were supported to maintain their independence. This was reflected in feedback from those living at the home. One person told us, "I have my independence, I can go out when I want and do what I want." Although support plans detailed areas in which people were independent, more information was required to ensure risks associated with this were managed.

People's right to privacy was respected. People we spoke with told us they could have privacy in their bedroom if they wished and people were able to choose to lock their bedroom doors. One person told us they could also make use of an upstairs lounge area if they wanted privacy. Staff understood how to respect people's right to privacy and we observed that this was put into practice for the duration of our visit. For example observed staff knocking or bedroom doors and waiting for an answer prior to entering.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support. Each person who used the service had an individual support plan; however the quality of these was variable. Whilst some support plans were detailed and personalised others lacked detailed information and had not been updated to accurately reflect people's needs. For example, records showed one person had specific support needs related to their continence. There was no information about this or the support the person required in their support plan. Other support plans had not been updated to reflect learning from adverse incidents, so did not detail how best to support people to ensure their safety. These deficiencies in support plans placed people at risk of not getting the support they required.

People were offered the opportunity to get involved in planning their own care and support. One person told us, "[Manager] discusses it with me from time to time and if I wanted to read it I could."
Records showed most people had chosen not to be involved, where this was the case the manager had written support plans on their behalf.

Prior to our inspection we received concerns that people's diverse needs may not be accommodated. We were informed that a potential new admission to the service had been refused a room at the service as the home had advised they would not be able to meet their cultural needs. This did not assure us people's cultural needs would be met. In contrast during our inspection, the manager told us they respected people's diverse needs. For example, one person living at the home came from a different cultural background from others living at the home. They were supported to cook meals which met their cultural preferences. However we remained concerned that people's diverse needs may not always be accommodated.

People were offered some opportunities to take part in social activities, however these were limited. People's feedback in this area was mixed, one person told us, "I am happy enough doing my own thing," in contrast another person said, "It would be nice to see more activities." We saw records of meetings where activities were discussed, however most people chose not to take part in any organised activity. The manager told us they had previously organised day trips and visits to local areas of interest but uptake was poor. People we spoke with told us that they were able to choose how they spent their time. One person told us, "I do what I like, when I like." Most people using the service were very independent and chose to spend a lot of their time in the community. During our visit we saw people socialising with each other, watching TV, listening to music and going out in the local area.

People were supported to maintain relationships with friends and family and people's friends and relations were welcome to visit Haven Lodge. The staff team had a good knowledge of who was important in each person's life and supported people to maintain relationships with family members. Relationships had developed between people using the service and we saw friendly interactions between people.

Although the service was not supporting anyone who was coming toward the end of their life at the time of our inspection visit, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their care plans.

There were systems and processes in place to deal with and address complaints. Some people we spoke with told us they would feel comfortable telling the staff or manager if they had any complaints or concerns. One person said, "I would speak with [manager] or [registered provider]. The manager would be right on it too, they are good like that." However, other people told us they would not feel comfortable raising concerns or making a complaint for fear of repercussions. Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the manager. Staff told us they were confident that the manager would act upon complaints appropriately. There was a complaints procedure on display in the service informing people how they should make a complaint. There had not been any complaints recorded since our last inspection.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Throughout our inspection of Haven Lodge we identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, safeguarding people from abuse, staff recruitment, person centred care. This led to multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is of concern that a number of serious risks to the health and safety of people living at Haven Lodge had not been identified prior to our inspection. This is of particular concern given the history of non-compliance with the regulations. At our previous inspection in August 2016 we found systems in place to ensure the safe and effective running of the service were not comprehensive or robust. We met with the provider who assured us action was would be taken to improve audits and governance systems. In November 2016 the provider sent us an action plan stating all required improvements had been completed. Despite this, during our November 2017 inspection, although we found some improvements had been made to some audit tools, the quality assurance systems were still not effective. Although audits had been conducted by the provider, a number of concerns found during our inspection had not been identified and consequently action had not been taken to safeguard people from harm.

Audits were not comprehensive which meant serious concerns about the safety of the service were not identified. For example regular 'bedroom audits' were completed, these covered areas such as the decoration of the room, some aspects of health and safety and cleanliness. However, the audits did not cover important health and safety issues such as window restrictors and risks posed by hot surfaces. Consequently the provider had not identified or addressed risks in these areas. There were systems in place to check the water temperatures to protect people from the risk of scalding, however these checks did not include the showers. As a result, we found the temperature of showers exceeded the HSE recommendations and placed people at risk of scalding. The failure to ensure robust, comprehensive audits placed people at risk of serious harm.

Where audits had identified areas for improvement the provider had not always ensured swift action was taken to address the issues. For example, bedroom audits conducted on 13 and 20 November 2017 had identified an unpleasant odour in one person's bedroom. No action had been taken to identify or address the source of the odour and at our inspection we found the room was still malodorous. The failure to take timely action meant the person's room was left in an unhygienic and undignified state for a prolonged period.

There were no systems in place to record, analyse and learn from incidents. Incidents such as verbal altercations and threatening behaviour were recorded in daily records but there were no detailed records of these incidents to allow analysis to prevent future occurrences. During our inspection we were informed of a verbal altercation between two people who lived at Haven Lodge. There was no detailed record of this. We asked the provider about this who told us it was "family banter" and it was about a new resident "establishing their place in the pecking order." The provider did not see this as a significant incident and consequently no action had been taken to try to prevent future occurrences. We also found other incidents

referred to in daily notes but no detailed information had been recorded. The failure to review and take appropriate action in response to this incident placed people at risk of harm.

The approach to quality assurance was reactive rather than proactive. In previous inspections of the home we identified there were no systems in place to keep up to date with good practice, during this inspection this continued to be the case. The management team told us they did not attend any local forums and they were not aware of other good practices resources. Consequently the provider lacked knowledge of the current legislation and guidance and this had led to a failure to mitigate risks to people living at Haven Lodge. For example, during our inspection we provided feedback regarding the failure to comply with HSE guidance related to hot surfaces and the restriction of windows. The provider told us they had not taken action prior to our inspection as they were not aware of HSE guidance. This failure to keep up to date with guidance and legislation placed people living at Haven Lodge at risk of serious harm.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of safeguarding incidents reported to the local authority. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff felt supported in their roles and told us the management team were friendly and approachable. One member of staff told us, "I would go to [manager] if I had any concerns, I have confidence in them." Another member of staff said, "I think [manager] is a good manager, easy to talk to. We are free to talk to them." Staff were able to offer feedback on the service in supervision meetings and team meetings. Records showed staff meetings took place regularly and were used to review the care of people living at the home and to discuss issues.

People living at the home were provided with opportunities to provide feedback about the service at monthly meetings. Records of the most recent meeting showed these were used to discuss areas such as, food, the environment and activities and also to remind people of safeguarding procedures. The manager told us that they conducted an annual survey for people living at the service. We saw copies of surveys with actions noted on them based upon people's feedback. One person had made a suggestion for a particular activity in the most recent survey and we saw this had been included in the activities schedule.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the home, the provider did not have a website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications of safeguarding concerns were not submitted to the Commission as required. 18(1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with person centred care which met their need and preferences. Regulation 9 (1)

The enforcement action we took:

We took action to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act 2005 were not respected. Regulation 11 (1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected from the risks associated with their care.

	Environmental risks were not identified or mitigated. Medicines were not safely managed. Regulation 12 (1) (2)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate action was not taken to ensure that people were protected from abuse and improper treatment. Regulation 13 (1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. Action was not taken in response to know concerns. Systems were not in place to record and investigate incidents which posed a risk to the health and wellbeing of people who used the service. There were no systems in place to keep up to date with good practice. 17 (1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitments practices were not in place.

19(1)

The enforcement action we took:

We took action to cancel the registration of the provider.