Care Homes UK Ltd

Haven Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Haven Lodge took place on 5 and 7 February 2018 and was unannounced. The previous inspection in July 2017 had rated the home as inadequate and it was placed in special measures. Six breaches of regulation were found, three of which resulted in warning notices for safe care and treatment, governance and staffing. The other three breaches were in relation to consent, nutrition and equipment and resulted in requirement notices. The provider completed an action plan to show they were going to address the concerns raised and during this inspection we looked to see if these improvements had been made.

Haven Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Haven Lodge accommodates 32 people in one adapted building, in single rooms. During this inspection 27 people were living in Haven Lodge.

There was a new manager in post who was in the process of registering with the Care Quality Commission. 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 and their relatives were keen to tell us about the improvements made since the previous inspection. The appointment of a new manager was a significant part of this as they were visible and open to addressing any issues. The atmosphere in the home was positive and staff, for the most part, were calm and supportive in their approach.

People told us they felt safe and staff knew how to report concerns to the manager; confident they would be addressed and monitored. Learning from concerns was shared with all staff. Although there were still areas which needed further development, it was clear the groundwork had been laid to establish better outcomes for people.

Risks were more constructively managed, although some documentation needed further cross referencing with people's care needs. Moving and handling practice had improved and staff appeared confident in the techniques required. All staff had received further training in this area.

Staffing levels were more appropriate to meet people's needs and further recruitment checks were in the process of being made to ensure all were in place as required.

Medication administration practice had improved although there were some minor issues. These were addressed promptly by the manager who was keen to ensure best practice. Infection control was also subject to further improvement and staff had received additional support in this area.

The manager was aware of guidance and how to follow it. They were in the process of ensuring compliance with the requirements of the Mental Capacity Act and showed what work they had undertaken so far. There was more to be completed, but it showed an understanding of the process and requirements. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Nutritional and hydration needs were better met for people with clearer documentation in place. Staff had access to food and fluid charts which were completed in detail and a system had been developed which ensured any risks were flagged up on a daily basis. However, not all staff were aware who was at nutritional risk. We saw action where concerns were raised was both prompt and appropriate, with referrals made to other health and social care services as necessary.

Staff were compassionate, caring and kind in their approach, and apart from one instance which was immediately dealt with, respected people's privacy and dignity. Relatives were invited to share in supporting people, through meetings and events along with reviews of people's care needs where appropriate.

Care records had been improved and were more comprehensive than during the previous inspection but there were still inconsistencies in recording and reflecting people's changing needs. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not always accurate or complete.

Complaints were handled sensitively and discreetly addressed, as far as possible.

The manager had been in post for four months at the time of the inspection and the progress they had made was evident. Staff were more settled and comfortable and told us they felt able to raise any issues. The manager provided leadership and was clear in their vision for the home. Along with the provider, they had shown commitment to focusing on improved outcomes for people, while being realistic at the scope of improvement still needed.

We have made a recommendation in regards to staff deployment and you can see what action we told the provider to take at the back of the full version of the report.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of 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?

Requires Improvement

The service was not always safe.

We found gaps in recruitment checks and medication was not always managed safely.

Improvements to risk assessments had been made but not all were detailed enough.

People felt safe and staff knew how to respond if concerns were raised.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was in the process of obtaining people's consent to care and other specific decisions.

Staff training was in progress and they were supported with supervision.

Nutrition and hydration needs were better supported with clearer documentation and people had access to health professionals as needed.

Is the service caring?

Good

The service was caring.

Staff were patient, kind, caring and showed a genuine interest in people's wellbeing.

The home had positive relationships with all relatives who visited.

People's privacy and dignity was respected apart from one instance which was immediately dealt with.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records, although some improvement had been made, did not always reflect a person's overall needs.

Complaints were acknowledged and dealt with promptly.

End of life care needs and wishes were recorded in detail following people's preferences wherever possible.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was marked improvement across all areas of the home but there were still areas which needed further development and embedding.

A more robust quality assurance system was being implemented which indicated the manager was focused on better outcomes for people.

People and relatives spoke of the positive atmosphere and the differences since the last inspection.

Haven Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 7 February 2018 and was unannounced on both days. The inspection team consisted of one adult social care inspector, an assistant inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we requested a Provider Information Return (PIR) which was returned to us. 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 checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with six people using the service and six of their relatives. In addition, we spoke with seven staff including four care workers, the cook, the deputy manager and the registered manager. We also spoke with a visiting health professional.

We looked at seven care records including risk assessments, three staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

At the last inspection this key question was rated inadequate due to concerns with risk assessments, poor moving and handling practice, insufficient staffing levels and medication management including storage and records. During this inspection we found some improvements had been made.

Everyone we spoke with told us they felt safe. One person said, "Everything makes me feel safe, they look after you and the nurses are lovely." Another person told us, "I definitely feel safe. Everybody around me is alright and if I ring my buzzer they come and look after me well." A further person shared with us, "I feel safe because I have never seen anything to worry me."

Relatives echoed this view. One relative told us, "My relative walks about on their own but staff keep a check on them to make sure that they are safe." Another relative said, "We feel confident that our relative is safe because if anything happens they are always on the phone straight away. There is good communication and they tell us everything, they are open about everything and update us each time we come in. They are proactive."

Staff were able to identify different aspects of what may constitute a safeguarding concern and how to report concerns within the organisation. We looked at safeguarding records and found appropriate and timely referrals had been made. If learning or further training needs were identified from incidents, this was shared with staff via staff meetings and handovers.

We still had concerns about staff recruitment checks as not all had been completed further to our last inspection. We found not all previous employment history had been investigated in depth and there continued to be a lack of appropriate references. However, we saw this had been noted on the provider audit and was in the process of being remedied.

Staffing levels had increased since the last inspection and people told us their needs were usually met promptly. Some people and relatives commented on how busy staff were and so they did not always have time to sit and chat. One person told us, "The staff are all right but they are pushed sometimes. There are four staff and a manager but some people need two people to help them."

We asked staff if they thought there were sufficient numbers to support people safely. Comments included, "I would say that staffing levels are good, it was hard a few weeks ago but now it's definitely improved, we don't have much sickness either," and "There is always enough staff to keep people safe. We use agency sometimes but we've cut down now." Staffing rotas for the preceding two months showed staffing ratios had been met on all occasions to manage sickness and holiday cover. Consistent and appropriate levels, based on people's needs, of five day staff and three night staff were provided, along with the deputy and home manager.

The management of risk was more robust than at the previous inspection. Staff were able to explain how to manage in the event of an accident and one care worker said, "I feel confident that staff know what they are

doing if an accident happens but people are kept safe." Another care worker told us the senior care worker would always give direction but "if we witness what happened, it's us that fills in the accident and incident forms." One person we interviewed in their room had access to their call bell and explained they used it if they needed any assistance. Another person was reliant on a sensor mat in their room to which staff responded promptly as we accidentally set this off.

Staff displayed knowledge of how to respond in an emergency including a fire. One carer explained, "We dial 999 if it's an emergency but the seniors deal with it. For example, if there's a head injury that's what we do. A fall happened last week and we just missed it by a few seconds. I feel confident that we know what we're doing if this happens."

We checked the personal emergency evacuation plans (PEEPs) and saw they had all been updated on 31January 2018. They accurately reflected people's needs which was an improvement from the previous inspection. People with higher dependency needs were quickly identifiable and the plans included clear evacuation instructions.

We observed safer moving and handling procedures than during the previous inspection. We observed two care staff using a hoist to reposition a resident in the lounge. Staff gave clear explanations throughout the transfer maintained the correct position. The procedure was at a steady speed and the person was offered reassurance throughout. This was also mirrored when staff used the stand aid. Some risk assessments needed further detail as to the equipment and methodology used.

We asked staff if they had all of the necessary equipment they required to do their job effectively. A second hoist had been purchased for the home since the previous inspection. Equipment checks had all been carried out as required under statutory legislation.

Accident and incident records were completed in detail, with few resulting in significant injury. Post fall observations were also recorded accurately and detailed any changes to a person's condition which may need further attention. There was a clear oversight by the manager who had reviewed each accident in depth and also considered further possible risk reduction measures. Notifications to the local authority and the Care Quality Commission had also been made as required.

Risk assessments were in place for promoting skin integrity, nutrition and hydration, moving and handling, mobility, bed rails and other equipment and the use of call bells. The checking of equipment was more robust than during the last inspection as daily and weekly checks were conducted for equipment including, bed rails and the hoists. All relevant premises checks had also been carried out as required.

People and relatives we spoke to told us people received their medication on time and had access to pain relief when required. One care worker told us, "I have had recent training in giving medication; this was done in a booklet and signed off by a manager." A medication issue was noted by this care worker during our observed medication round due to a pharmacist error which was promptly dealt with. Staff's medication competency was checked at least quarterly and the manager explained what was being assessed. We found these checks were thorough and questioned staff's knowledge along with an observation of their practice.

We observed where medication was prescribed PRN or 'as required' the administration time was recorded so staff knew when it was safe to administer a further dose. The care worker signed the medication administration record (MAR) after they had ensured the person had taken their medication. MARs contained all relevant information including key medical information, a dated photograph to aid identification and whether the person had any allergies. If a person had refused their medication this was clearly recorded and

appropriate follow ups with the GP occurred. The application of creams was recorded on a topical MARs stored in people's own rooms, although not all were dated which meant it was not always clear if the guidance was still current. This was remedied immediately after our inspection. We checked these on the second day of the inspection and found staff had clear instructions to follow and were applying as directed on the document.

We advised the manager the care worker was not wearing gloves while administering medication and they agreed to remind staff of the importance of this. We also noted where people were due to have medication at specific times, such as 30 minutes before food, the actual time of administration was not always recorded. The medication round on the first day of the inspection took some time to complete as the care worker advised us they had started it at 8.30am and still had seven people to support at 10.10am. They were still wearing their medication 'do not disturb' tabard at 11.15am with the lunchtime medication round due to begin at 12 noon. Although this did not impact on any specific medication, it meant the care worker had spent most of their morning supporting people with medication alone. We discussed this with the manager who explained usually the deputy manager and a senior care worker would administer medication from each trolley but due to an emergency that morning this was not possible.

We checked the medication room which was in need of a clean as the sink was dirty. We found one person's cream was correctly stored in the fridge but another person's was not. The room temperature was recorded daily but was only just within the correct range despite the fan being kept on constantly. The manager advised they had separated the medication into two trolleys but this meant one trolley, although secured to the wall and locked, was in a room where the temperature was not controlled. The manager had bought a thermometer by the second day of the inspection and was to buy some blackout blinds to aid keeping the room cool. Controlled drugs were stored correctly although we noted a date error in the record book which was promptly corrected.

The manager responded promptly to our concerns and sent supporting evidenced to show how the above issues were being dealt with such as a change to the administration of time specific medication in support with the pharmacist, better stock control checks and personal protective equipment being available on the medication trolleys.

The people and relatives we spoke to told us the home was clean. One person we spoke with told us that the cleaning lady is 'marvellous.' One relative who visited daily said, "It's clean, it never smells and it's been like that since I looked around." The manager told us a new sluice room was due to be completed very soon and we saw this was in progress. They explained they had received assistance from the local authority infection control team in setting up more effective systems.

Requires Improvement

Is the service effective?

Our findings

During the last inspection we found concerns with nutrition and obtaining consent. During this inspection we found improvements had been made, although there were still issues with the serving of meals and staff training which had expired for some staff.

Staff advised us they completed a two day induction programme before commencing employment at the home. One care worker said, "I mainly did shadowing and training booklets. It was good and I enjoyed it." Another told us, "Everyone was given training books and we were shown fire zones."
Staff had completed key training in subjects such as infection control, mental capacity and deprivation of liberty safeguards, food hygiene, dementia and first aid. However many staff were due updates in medication administration, safeguarding, fire safety and dementia awareness which the manager had scheduled. Staff described two people with more complex behavioural needs but said they had not received any specific training as to how to support them. However one told us, "If this ever happens, we just get down to their level or walk away and let them calm down. This usually works." The care certificate was not being used by the provider which provides a minimum set of standards for care workers to use.

We reviewed staff supervision records and saw staff received regular supervision. We noted a programme of specific topics such as safeguarding and dementia had been scheduled for the year ahead.

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.

Staff told us they had received training in understanding MCA and DOLS. However, their knowledge was vague as one care worker could not say who had a DoLS in place, and the other told us, "I'm not sure if we have anyone or not, we have people with dementia here though." We discussed how the manager was addressing the concerns we found at the last inspection and they explained they were in the process of assessing specific decisions for people and documenting the outcome in line with the requirements of the MCA. We saw evidence of this and were happy the process was understood correctly. The manager was aware this was still a learning area for staff and would continue to explore this area in staff supervision.

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. We found monitoring was now taking place in line with the conditions on people's DoLS.

The people we spoke with told us they could make everyday choices themselves such as when to get up or

go to bed, and were not restricted in any way, and that these choices were respected. People in their rooms were there through their own choice and regularly checked by staff. People also confirmed they were asked their consent before any care support was provided. One relative told us they had seen staff asking for consent from people living at the home, such as if they wanted an apron at lunchtime. Another relative told us, "The staff are great, really good. They always ask for consent and I have seen them do it with other people as well. They encourage my relative to eat if she can." We observed another person being repositioned in their armchair in the lounge and staff asked for consent before supporting them with this activity.

The environment was bright and communal areas well lit. Signage, particularly helpful for orientating people with dementia was present to assist people in navigating round the building. Bedrooms were well decorated, homely and personalised. Relatives told us the home's internal and external environment was pleasant and appropriate for people.

People told us staff contacted the doctor if they were feeling unwell and relatives confirmed this. Other people advised they had seen the optician and the chiropodist. Relatives told us that staff contacted them if people's needs changed and were kept informed of any concerns. We saw evidence of these visits in people's records. We also spoke with a visiting health professional who told us, "There has been a massive improvement since the last inspection. Staff are always helpful and understand the importance of regular pressure relief."

People had access to drinks mid-morning and afternoon, and also were offered a range of snacks including fruit, biscuits and mousse. People and relatives told us the food was good, there was enough to eat and always a choice which we saw people being offered. We noted some people did not drink much and staff did not always prompt people to do so. We found people in their rooms did not have access to jugs of water but were offered drinks when they were served at specific times during the day.

People chose where to eat their meal and were given appropriate aids to promote independence such as plate guards and specialist cups. Food was also of the appropriate consistency where people had specific swallowing issues. One person did not have much appetite but staff pro-actively encouraged them to eat, offering an alternative savoury meal and then a pudding. Another person was struggling with a sore mouth but their soup was thinned to aid swallowing. Staff sat and supported people patiently and sensitively. Although staff did support people with nutrition if needed, this was ad hoc and we observed one person had three different members of staff providing assistance.

The serving of meals at lunchtime was disorganised on the first day of the inspection but we observed a much calmer experience on the second day. We observed one person on a table would be served while the others had to wait ten minutes for their meal. This was mirrored during the whole mealtime at different tables. One person who was asleep was brought their meal but another person had to wait a further few minutes before theirs arrived. There were enough staff to give support to those who needed help to eat but their deployment was not effective. We recommend the provider considers how staff are deployed at busy times of the day. People who ate in their room were served promptly at the beginning of lunchtime, and staff supported if they needed assistance. People were offered and provided with an alternative if they did not like their initial choice.

Staff's awareness of who was nutritionally at risk was mixed. One care worker told us, "There's a list kept in the kitchen that we look at and tells us what we need to know. I don't know how many people are, 8 or 9 maybe". However, a different care worker was not sure. Kitchen staff had access to up to date records where people's dietary requirements were logged. We saw food and fluid charts were completed in detail showing

actual consumption levels, with specific targets for people, and external support was obtained for people at risk. Where people required thickening agents to avoid choking, specific guidelines were recorded for staff and these were kept securely. The manager discussed one person whose medication was affecting their appetite and routines, and how they had requested a further review. People's weight was regularly obtained and records detailing any concerns showed action was taken if required. If people had been unwell or in hospital this was duly noted on the analysis to show why there may have been a deterioration.

Staff confirmed handovers was completed at the beginning and end of each shift. They were fully documented and the manager was in attendance.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with were positive about the staff at Haven Lodge. They told us staff were kind and caring, treated people with respect, listened to them and acted on what they said. One person told us, "I have no problems with the staff. I think they do their jobs and that is the main thing." Another person said, "The staff are smashing. You can't pull them to bits because they are brilliant. They treat you with respect and will call you Mrs so and so if you want but I like to be called by my first name. They do everything they can to help you." Other comments included, "I have been here a long time and I am happy with the staff" and "The staff seem quite nice. I cannot fault them."

Relatives spoke equally positively telling us, "The staff have a friendly manner and are very empathetic. Our relative is independent and mobile and staff encourage this while keeping an eye on her to check that she's managing ok." Relatives we spoke with also told us their relatives were always appropriately dressed and well presented when they visited.

We observed care interactions which were attentive, caring and kind. People seemed comfortable with staff who were gentle and reassuring. There was some banter between staff and people. Staff got down to people's level when communicating with them and had good eye contact. We observed one care worker assist a person to join in the activity with the parachute, gently encouraging them to hold it and ensuring they were comfortable.

People told us staff treated them with dignity and respected their privacy. One person told us, "The staff always knock and wait and explain what they have come for." However, although most people told us staff did knock before entering a room, they also said not all waited before entering the room. We observed some staff doing this and also observed one care worker entering someone's room without knocking at all. We discussed this with the manager who promptly spoke with the member of staff and agreed to remind all staff of the importance of respecting people's privacy. The manager was in the process of sourcing specific training around dignity in care.

All the people we spoke with who needed help with personal care told us staff respected their privacy and dealt with them in a very sensitive manner when supporting with personal care. People told us staff kept them covered up with towels, only the members of staff helping them were in the room and that the curtains were pulled. One person said, "Staff are lovely. They respect you because they do what you ask them to do. Nobody comes in while they're seeing to you and they pull the curtains. I am used to doing things for myself and they encourage that."

All the relatives we spoke with told us staff encouraged their relatives to maintain their independence. One relative told us that in a previous home their relative was put in a wheelchair to be taken to the toilet rather than encouraged to use their zimmer frame which resulted in a loss of muscle tone. However, they explained staff at Haven Lodge encouraged their relative to use their zimmer frame and as a consequence their relative's mobility had improved.

People told us that their personal preferences were respected such as the gender of their care worker. The manager said the local priest visited for people who wished to share in a service or have some individual time. People had access to advocates if needed.

Most people did not recall being part of the care planning process but relatives had contributed. Staff explained, "We talk to them when they come in to visit." The manager responded immediately post inspection with some new documentation to ensure these conversations were clearly documented.

Requires Improvement

Is the service responsive?

Our findings

One relative told us, "People get the care they need; the staff are friendly and approachable. We have no complaints at all."

We observed people had the opportunity to join in activities under the direction of the activity co-ordinator. They were very enthusiastic and urged people to engage as much as possible. People who chose to remain in their own rooms were also encouraged to join in if they chose to. We observed a group exercise session in the lounge and a group of three people playing ludo; in the afternoon a quiz was held. There was also individual support for people as one person was supported with a jigsaw.

Relatives spoke positively of the opportunities available to people on a daily basis. We were told about bingo, quizzes, reminiscence activities, entertainers and trips out. One relative we spoke with told us people were offered a choice of magazines they liked to read. They also said there were activities most afternoons and staff really got people involved and talking. Another relative we spoke with told us that their loved one had said, "I'm enjoying this, come back tomorrow!" when they had visited on a particular day. People were taken out into the local community twice a month for lunch, attending a local facility. Relatives stressed they were always welcome at the home and could visit anytime. They also had access to private meeting space if this was preferred.

One care worker told us, "There's definitely lots to do, the activities co-ordinator is really good. They have a cupboard full of things to do. Residents go out on outings as well to bingo, for food and to the fire station'. Another care worker said, "There is loads to do for residents. There are different things on different days and nail painting, stuff like that."

Care records held key information about emergency contacts and life histories where it had been possible to obtain these. People's preferred routines were also noted. Care records contained details of personal care needs, nutrition, communication, mobility, medication and people's mental health needs amongst others. One record stated, "[Name] is able to wash their hands and face but will need help choosing clothes." Any specific conditions contained information sheets for staff to improve their understanding. Some records were completed in more depth than others.

As before, although people's care needs were evaluated monthly there was not always evidence of when a person's needs changed, how this impacted on other areas of a person's care. In one person's record their skin integrity was scored as high risk and yet their repositioning support needs had diminished. There was no evidence to indicate why this had taken place. People who needed assistance with re-positioning had charts kept in their rooms showing when staff had assisted and these were regularly completed in line with people's care needs.

There was not always evidence needs had been met as far as possible. One person's record stated they suffered 'intermittent pain' but there was no care plan indicating how this was to be managed. There were also some inconsistencies in recording. For example, one record contained two body maps. One dated

January 2018 stated, "[Name] has red markings on both of their feet and a bruise on their right hand" but there was no further documentation or evidence to identify why this bruise had occurred. A previous record dated December 2017 stated "[Name] has an ulcer on his right foot at the top. District nurse is aware and is visiting to redress, the rest of the skin is intact." However, this person's corresponding mobility and dexterity plan did not refer to any such concerns.

In another person's record, a mobility care plan identified them as a high falls risk in January 2018; however this was a typed copy from another care home, not Haven Lodge. Staff had crossed out the care home name and replaced this in biro pen with Haven Lodge. This was contradicted by a completed mobility and dexterity assessment which identified the person as a medium falls risk; this was also edited from another care home. We noted the person had fallen mid January which had resulted in a hospital admission and therefore should have been classed as at high risk of falls. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not always accurate or complete, reflecting people's care needs.

Staff admitted to not using the care records on an everyday basis. One care worker said, "I know relatives are involved but seniors complete them or the deputy and manager. We do have access to them but I've never read any apart from getting phone numbers." Another staff member told us, "We can access them and read them if we want, seniors do monthly audits." Despite this, we observed staff meeting people's needs in line with their records. One person's notes read, "Staff should prompt with close supervision and assist due to poor swallowing reflex" which we observed.

None of the people we spoke with had ever made a complaint but they knew how to if required. There was a system of acknowledging, investigating and responding to complaints. The service had received two complaints since our previous inspection. One complaint response we reviewed had a limited response due to the confidential nature of the concern raised but the other complaint was responded to in depth. Staff were vague about the complaints process but one care worker did say, "It depends really, I know the manager deals with them. We do pass them on if we get any but we try to resolve concerns where we can."

Some relatives we spoke to told us the home had spoken to them about end of life care wishes. We asked staff how they supported people at the end of their life. One staff member said, "We don't treat people any differently, we just look after them in bed instead." They were able to tell us who was needing more care. Other staff knew who they needed to check on as they did not leave their rooms. We found evidence of these regular checks recorded in people's rooms. One person unfortunately passed away on the morning of our inspection. We observed the person's relative visit the home with flowers, a card and thanked all the staff present for "looking after my [relative] so well; you've all done so much. I wish I could give you more."

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about Haven Lodge as a place to live, describing it as friendly. One person said, "It's a good place and the staff keep it going. I'm proud of the staff." Another person told us, "It's clean, they look after you and you get plenty to eat." A further person said, "I want to be at home but I can't live on my own, so whatever they do for me I am grateful. I would recommend the place because they look after you well. A relative has just moved in." All the people we spoke with said they would recommend the home to others.

Relatives confirmed the home had improved. One relative told us, "I visit every day and my brothers also visit. It has improved since the last inspection; there is more paperwork filled in for example, food charts, fluid charts, turning records etc. My relative has a pressure mat in case they get out of bed." Another relative said, "This place is well managed because staff are not patronizing to people, you can see that by the way they interact with them and that goes a long way. We would recommend this place because the staff are really nice with the residents." Monthly newsletters assisted with the sharing of forthcoming activities and events, encouraging relatives' involvement.

The home had a manager who was undergoing their registration checks with the CQC at the time of the inspection.

People were happy to raise any suggestions directly with the manager and felt they were approachable. Relatives were aware of the meetings arranged specifically for them to raise any issues and hear what the home had been doing. They told us the meetings were well advertised with plenty of notice. Some relatives had attended, and for those who had not, they knew they had the option to do so and could input ideas and suggestions if they wanted. All the relatives we spoke with said the manager was visible and involved in the home, much more so than the previous manager. They told us they could talk to the manager about their relatives' care and they were listened to.

We asked staff about the how the home was managed and whether they felt supported by management. One care worker said, "I do feel listened to. I feel confident that if I had any problems it would be dealt with right." Another said, "The home is well managed; it's definitely improving since I started because there was no manager for a while when I started. (Name of manager) is brilliant." A further care worker told us, "The manager is approachable and I feel confident that concerns would be dealt with properly." Staff told us, "This is a good place to work. I don't have any concerns in particular with anything. I did want to leave a while ago but now the new manager's here, I love coming to work' and "We work well together as a team generally."

Staff meetings were held on a regular basis where topics were discussed such as infection control, good practice at mealtimes, staffing, training, and the importance of person-centred care.

The manager had completed an action plan identifying where further improvements were needed. They advised us significant improvements had been made to the home such as the staff were working more closely as a team, and people were receiving better care. This was evident through the positive feedback

they were receiving and the improved documentation which showed staff were fulfilling their duties.

The provider and other registered managers in the care home group provided support and guidance which the manager found very useful. The provider visited at least monthly, producing a report of each visit, and was always available via telephone if needed, and there was no issue in acquiring any resources if needed. The provider kept a review of the progress of the action plan.

A more robust quality assurance system was in the process of being implemented. There were only one month's audits available to inspect but these included mealtime experiences, pressure ulcers, kitchen audit, infection control, care plans and medication audits. There was also a detailed pressure cushion audit completed in December 2017. Where equipment had failed, we saw it had been replaced. Audits provided clear and honest evidence of findings with delegated responsibilities for completion of tasks within specific timescales. All were checked by the manager. Weekly audits were also in place for areas such as medication, PEEPs, kitchen, training and supervision, maintenance and care plan checks.

We asked the manager how they ensured they were following good practice and they stated, "By leading by example and checking our performance against other care homes." The manager also completed daily walkarounds looking at care delivery, people's wellbeing and any significant events and the environment. They also spoke with people in the home for their views and the staff on duty. One person had said, "I didn't think I would go down to the lounge but I do and I enjoy it." It was evident if minor issues had been spotted, these were dealt with by the next day. The walkarounds also generated a daily manager's report which highlighted key themes and issues and meant greater transparency about the performance of the home.

We asked the manager what they felt the key risks to the home were and they told us, "Ensuring all staff are trained and managing medication safely." They shared with us their achievements including improved documentation which better reflected people's needs, weekly weight monitoring for those at risk, daily management checks and more detailed reporting to the provider on a monthly basis, improved auditing, consistent staffing, improved environment and frequent equipment checks. They were also proud of the cultural shift in the home which was commented on by people and relatives, and observed by the inspection team.

We asked staff what they would change about the home if they could. One commented on the décor which they felt was a bit outdated. The manager said their vision for the home was to be outstanding. There was a plan to implement electronic care plans which provided alerts for staff if tasks had not been completed.

The previous inspection ratings were on display along with the registration certificate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were not always accurate or complete.