Georgetown Care Limited

The Haven

Inspection report

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30 November 2016
01 December 2016
02 December 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection over four days. In November 2016 we received information of concern about unsafe recruitment practices. We carried out an unannounced inspection at the home on the 17 November 2016. Due to the concerns identified at this visit we changed to a comprehensive inspection so that we could have a detailed look at all areas of the home. We returned on the 30 November 2016 and this visit was unannounced. We continued with the inspection on 01 and 02 December 2016.

The provider had not ensured that people were protected from risk as robust employment checks had not been completed.

The home was in a significant poor state of repair and people were placed at risk because of this. Due to concerns identified in the electrical systems at the home we asked the provider to seek immediate advice from a qualified electrician to ensure the safety of people.

We contacted the environmental health officer due to the concerns we found in the safe handling of food and the poor state of cleanliness and repair of the kitchen. The Environmental health officer visited and has downgraded the food hygiene rating for this service from a level five to two. Five being the highest rating and one being the lowest. The Environmental health officer has told the provider they have to make improvements. Staff had not received the appropriate training in relation to safe food hygiene practices and infection control was poor.

Prior to the inspection we were made aware of one person who had developed pressure ulceration (sometimes called pressure sores) as a result of equipment not working. The provider did not notify us of this. The local authority that is responsible for investigating safeguarding concerns, substantiated the safeguarding concerns raised.

There was not sufficient staff employed. Care staff had taken on additional roles such as cooking, cleaning, laundry. This impacted on the time that care staff had to spend with people either delivering care or providing meaningful activities. During the inspection the manager told us they had recently offered two people the position of cook and cleaner pending successful references.

Not all staff showed a caring approach to people. There was limited interaction and staff did not have the appropriate skills to support and engage with people who were not able to verbalise. Staff did not maintain people's dignity and self-esteem.

When assisting people to eat, staff did not explain the food content or make conversation to enable a more pleasant experience. Some people were not supported to eat and drink sufficient amounts. People who were in the lounge during the day time were not offered drinks apart from set times. Medicines were not always administered safely.

Care plans were not person centred and were task focused. Records did not demonstrate a clear understanding of the Mental Capacity Act 2005. Not all people were properly assessed or monitored in terms of the risks to their safety and wellbeing.

Staff told us they received training however during the inspection staff did not demonstrate the necessary skills when communicating with people, infection control and the MCA 2005.

Staff had not received regular supervision with their line manager to discuss their performance or personal development. The manager told us they were in the process of implementing a new schedule of supervision dates. Staff told us they felt well supported by each other and the manager.

Quality assurance systems, governance and the audits in place had not identified shortfalls in the provision of the service and there was a lack of effective monitoring of the environment to ensure people were safe. There was no analysis of accidents and incidents to identify possible trends or triggers, to minimise further occurrences.

There was not a Registered Manager in post. The Registered manager had recently left the service and the deputy manager was "acting up" in the interim. Following the inspection the provider told us that the Deputy Manager had been promoted to the post of manager and would be submitting an application to be registered with us.

Due to the concerns identified at this inspection we wrote and subsequently met with the provider to express our concerns and, given the lack of investment in the environment and buildings, to seek assurances about the financial viability of the service. We are also working with the local authority to ensure the safety of people at the service.

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.
You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff did not undertake safe food hygiene practices.

The environment was in a poor state of repair and was unsafe.

People received their medicines on time. We found some errors in the administration of medicines.

We raised a whole home safeguarding alert due to the range of concerns we found.

Is the service effective?

Inadequate

The service was not effective.

People did not have a say about the choice of menu. Not everyone received appropriate support to eat and drink.

Staff have varying levels of understanding around the Mental Capacity Act 2005 and how it affected the way they supported people.

Staff had not received training in communication to be able to interact with people and not all staff demonstrated an understanding of cognitive impairment.

Some people did not attend health appointments and staff were not proactive in ensuring people received appropriate support from health professionals.

Is the service caring?

Inadequate

The service was not caring.

Not all staff communicated with people in a respectful way or protected people from unnecessary criticism.

Some people were not supported to wear appropriately warm clothing and footwear.

People's privacy and dignity was not protected whilst using the toilet facilities.

Is the service responsive?

Inadequate

The service was not responsive.

People did not contribute to making suggestions about the activities and events they could take part in.

People who were prone to social isolation were not supported through sufficient contact and company.

Care records were not reviewed appropriately to ensure people received care and treatment which met their needs.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to carry out effective auditing of the provision of safe care and treatment.

The provider did not submit when required notifications which were a condition of their registration.

The quality audits carried out did not identify the shortfalls in relation to the environment, care planning, staffing levels and medication.

The Haven

Detailed findings

Background to this inspection

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

We received information of concern in November 2016 and carried out an inspection on 17 November 2016. At this inspection we found further areas for concern and carried out an unannounced comprehensive inspection on 30 November 2016. The inspection continued on 01 and 02 December 2016. The inspection was carried out by one inspector, a specialised advisor 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.

We spoke with six people living at The Haven care home and also observed the care and support people received. We spoke with four relatives and one visitor about their views on the quality of the care and support being provided. We spoke with the provider, the manager and deputy manager, a senior care worker and two other staff. We looked at people's care records and documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Inadequate

Is the service safe?

Our findings

In November 2016, we received information of concern about unsafe recruitment practices. During this inspection we confirmed that one member of staff was working in the building without the necessary employment checks being completed. This staff member did not speak English and we communicated with them via another member of staff who spoke Bulgarian. This newest staff member had been employed as a cook/cleaner. They told us that they had not completed any training for this role as they could not understand the training provided due to the language barrier.

The provider failed to identify and assess the potential risks to people's health and safety arising from poor standards of cleanliness and unsafe food and infection control practices.

An acceptable standard of cleanliness had not been maintained in the kitchen. The outside of the kitchen units had in-ground dirt on them and the inside of the cupboards were not clean with food debris, stains and dust. The back of the pedal bin was dirty as was the floor which had old food spillage around the kitchen units. Inside the cooker was not clean and there were rusty baking trays. There was a build-up of dust between the kitchen units and the fridge and freezer. The side of the freezer was covered in heavy grease marks. Several walls in the kitchen were mouldy and coloured food boards were stored on a rack on the floor. The boards had stains on and were not clean. There was heavy dust and dirt under the food board rack.

Staff did not adhere to safe food hygiene practices. Staff cleaned the top of the work surfaces in the kitchen with an anti-bacterial cleaner, however they did not keep the cleaner on the surface long enough to enable it to thoroughly clean and decontaminate the surface. Dishes, cups and other crockery were washed by hand in the sink and there was no method of telling if the water was hot enough to fully clean the crockery. Some cups and teaspoons were stained from a lack of effective washing.

The hand sink in the kitchen did not have a visible sign that it was for hand washing only. A member of staff had placed a bottle of milk to defrost in the sink which was intended for hand washing. This practice could lead to cross contamination where staff had washed their hands. Due to this, staff were unable to wash their hands in the designated sink prior to preparing food or administering medicines.

The manager was unable to locate the recording book of the fridge and freezer temperatures prior to 21 November 2016. We were therefore unable to ascertain if the temperatures had been checked on a daily basis to ensure food was being stored at a safe temperature. The freezer had not been defrosted and was one third of the way full of ice. This could result in the appliance not working effectively and therefore not freezing food to a safe level.

Food in the fridge had not been labelled with the date it was opened and a date by which it should be discarded by. Staff could therefore not be assured that people were not eating out of date food. A packet of out of date bacon was in the fridge and had not been disposed of. The bacon was not wrapped securely and had been placed over a packet of cheese which also had not been securely wrapped. This posed the risk of

raw meat contaminating a diary product and putting people at risk of a food borne illness.

In the fridge was a bowl of chicken stew which was served to people as their lunch. The bowl had not been covered to prevent contamination with other foods and the item had not been dated to ensure it was being eaten within a set date. There was no documentation around safer food management which identified risks and gave guidance on safe food hygiene practices. Due to the level of concerns we found in the kitchen we contacted the environmental health officer who visited the home during the inspection. The environmental health department have downgraded the home's food safety rating from a five to a two. Five being the highest and one being the lowest rating. Following the inspection the Environmental health Officer has informed us that a deep clean of the kitchen has taken place.

There was a lack of facilities to wash commode pots, and guidance to staff on how to wash the commodes and what products to use. Staff were washing people's commodes in the laundry room sink which posed a risk of waste from the commodes contaminating people's clean clothing and bedding. The manager told us they had a system in place to segregate dirty and clean laundry as staff would put the dirty laundry into a basket and not on top of the work surface. However, we saw washed laundry had been put into the same baskets which held the dirty laundry and there was no guidance for staff or products in place to sterilise and clean the laundry basket in between the different uses.

There were no instructions for staff in the laundry room as to how laundry items should be segregated, processed and stored. We found no evidence of appropriate resources being available to staff such as red bags to transport soiled linen to the laundry room or to use within the washing cycle. This increased the risk of an infection hazard for staff who dealt with soiled laundry. We asked the manager to provide us with evidence of the red bags being purchased and they did not provide this.

The level of cleanliness within the home was not of an acceptable standard. We asked to see the cleaning schedule whereby the manager told us they did not have one in place. We later found this document and for each day, all areas and items to be cleaned had been ticked as having been completed and to the standard required. We did not observe a clean environment which demonstrated that the cleaning had been completed on a regular basis.

During two days of the inspection there was no toilet roll in the first floor toilet, on the third day the toilet roll was refreshed. We found the lids of four pedal bins had broken which meant staff had to lift the bin lid and thereby risked contaminating their clean hands with an unclean lid. The front of a bespoke toilet seat had worn away to the metal which posed a risk of infection to people as effective cleaning could not take place. Likewise, the handle of a toilet and a soap dish had worn away to the metal. In the downstairs toilets, the toilet seat lid had been removed which meant when people flushed the toilet they were not protected from germs which linger in the air.

Carpets in the communal areas of the home were stained and had an odour of stale urine; the stair carpet was heavily worn with in-ground dirt. The linoleum in the kitchen was cracked in two places where food debris and dirt could harbour. The provider and manager were not sure if they had a working carpet cleaner and could not provide evidence that an external cleaning company had been employed to clean the carpets. We walked around the premises with the provider and pointed out the lack of cleanliness in the kitchen, shower room, bathroom, toilets and communal areas. The provider had plans in place to replace the lounge carpet and this was due to be done in December 2016.

We found shortfalls in the safe administration of medicines. We observed during the administration of medicines in the morning, the deputy manager interrupted their round to answer the telephone. They did

not wear a tunic which asked people to refrain from approaching them and on more than one occasion left what they were doing to respond to people and staff queries. Any distraction to the member of staff giving out the medicines could lead to errors being made. The deputy manager told us as they were the senior on duty that day they were required to answer the telephone. The provider had not considered safe medicine management as part of their staff planning.

The daily diary evidenced one person did not receive their medicine as required and there was a discrepancy with the number of tablets in another person's medicine stock. One person had recently moved into the home and had brought their medicines with them, however one of the medicines was incorrectly labelled. Whilst this was not the fault of The Haven care staff, they did not raise this with the GP as required. Medicines were kept securely in a locked cabinet in the quiet room, however, staff were not recording the daily temperature of the room to monitor it was set at the correct temperature to ensure the integrity of the medicines. This was important because the quiet room led directly into the kitchen through a swing door and staff used this door to access the kitchen, which generated heat due to cooking.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to maintain a safe environment and to monitor and implement timely repairs. We walked around the premises with the provider and highlighted concerns we had found with the safety of the environment. The premises had not been maintained to a standard which was safe for people and staff. The provider had not carried out risk assessments to determine the level of risk people faced and how these risks could be reduced. For example, a toilet seat was coming away, the bracket which held a fire extinguisher to the wall was broken, the inside of the microwave had started to disintegrate, windows were broken in the kitchen and conservatory, radiators in the conservatory were not covered, the kitchen units were in a poor state of repair and an upstairs carpet was rucked which was a trip hazard. The door on one of the downstairs toilets did not close properly and items such as sink plugs and chains were missing. There was insufficient room in the toilet to accommodate a specialised framed toilet seat. This meant the seat was turned sideways which gave little room for staff to support people. Throughout the home items had been removed from walls which left holes, cracks and exposed screws.

The catch on the window in the lounge was broken which was a potential risk to the security of the home. Due to the broken window in the conservatory, the temperature of the room was 12 degrees Celsius which is very cold. During the inspection we observed people going into this room. We asked the manager what a safe temperature should be for people who are frail and vulnerable and they were not able to tell us.

We found three enclosed rodent traps which typically contain harmful substances. One was placed in the conservatory, another in the downstairs toilet and one under the kitchen cupboard. The traps did not have a label on them which described the contents or the date they were activated. The provider had failed to assess if the traps were still required following a previous infestation of rats. A risk assessment was not in place to ensure that potential risks to people had been identified and all possible action had been taken to mitigate those risks. The provider had failed to consider that people with dementia may open these devices and ingest them, which could lead to serious harm or fatality. Following the inspection the provider informed us they had removed the traps.

Live electrical wires were accessible to people and could have caused serious harm, injury or fatality. A working wall light did not have a bulb in, an electrical ceiling socket in the kitchen had not been covered and an electricity meter with exposed wires had not been maintained. During and following the inspection the provider sent evidence that these items had been dealt with by encasing the electrical meter and covering

the ceiling socket. However, the provider did not provided evidence as requested that the electrical systems in the home were safe at the time of the inspection.

Outside of the premises, the patio area was cracked and was a slip hazard. There was an outside shed which housed various items. The windows were broken and the lintel above the doorway was rotten which had caused the inside ceiling to start collapsing. Staff were using the shed to store freezer items and activity materials and no consideration had been given to their safety. Upon the approach to the front door of the premises there was a wide gap in the paving across the width of the door, this was a potential trip hazard

There was green mould on the outside of the conservatory window and glass. The upstairs windows had not been cleaned and were visibly dirty with one window covered in cobwebs on the outside and obscuring the view. The provider told us they had used the services of a window cleaner but were not able to provide evidence of this.

Adjoining two communal rooms was a smaller room where people walked through. Balanced on top of the filing cabinet was an iron, leaning against the cabinet was an ironing board, a step ladder and a hoover. Any of these items could have caused injury to people as they had not been safely stored.

Recently some of the roof tiles were replaced at the front of the premises. The invoice from the contractor made a recommendation for a netting to be placed across an area of the roof to prevent falling debris. We asked the manager what steps they had taken to mitigate the risks of this occurring, however they did not respond.

Cleaning materials which contained harmful chemicals were not locked away securely. A cupboard on the first floor which contained these products was not locked and we were able to access it. People have access to the kitchen and in one of the cupboards we found a range of cleaning products and the cupboard was not locked. The provider had not considered the potential risks to people if these chemicals were ingested. There were three aerosol air freshener containers on a ledge in the hallway, which we asked the manager to remove because incorrect use of the product could cause harm to people. They subsequently removed the aerosol containers.

People were placed at risk of harm because relevant fire safety checks had not been completed. The fire alarm tests had not been carried out since 05 October 2016. A review of people's personal evacuation plans had not completed to ensure they were still relevant. The fire log book stated that the emergency lighting should be inspected monthly however nothing was recorded after 20 September 2016. Monthly evacuation drills had not been completed since 29 August 2016. Individual fire switch points were not being tested on a rotational basis. These checks were a requirement of an inspection plan following a visit by the fire department in 2015. At the time of our inspection there was no fire marshal in place, however the manager told us they would be taking on this role.

The emergency fire exit was blocked by a wheelchair and a weighing scale seat which could delay people from exiting the home in the event of an evacuation.

Some people used a pressured mattress to support good skin integrity and prevent pressure ulceration. There were no protocols in place for the use of this equipment, what should be checked and how often. No information was available as to the setting or inflation of the mattress and what staff should do if a problem occurred with the equipment. A new lifting hoist did not have information about when it should be inspected.

There was an entry in the daily diary of 20 September 2016 from the night care staff. They thought they should have a pager to wake up the sleep-in staff in the event of an emergency. It stated 'if X is found on the floor, I don't want to leave her to go up two flights of stairs'. The manager replied 'I will sort something out'. Following the inspection we asked the manager what action they had taken. We did not receive a response to our enquiry.

This was a breach of the Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was insufficient staff to be able to support people at all times. People and staff told us they did not think there were enough staff at times. During three days of the inspection, members of the inspection team were asked ten times for help and support by people. During the inspection we observed one person shouting out in a distressed state continually. This person received no reassurance or interaction from staff except when they were supported with personal care or at mealtimes. The staff rota showed a senior and two care workers were available during the day and two care workers at night, one waking and one sleep-in. However, there was a lack of additional staff to carry out designated roles, such as cleaning, cooking, laundry and providing activities. The day staff also carried out these roles and in addition the senior member of staff had time away from providing care as they carried out the administration of medicines.

There were three people who required the support of two care staff for their personal care in the morning, during the day and at night time. We asked the provider, with the current staffing levels how they ensured each person received timely support without having to wait until staff were available. The provider told us they used a tool to determine staffing levels based upon people's support needs. They told us they would provide evidence of this to us, however they failed to do this.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of a safeguarding concern regarding an allegation of neglect of one person. Following an investigation by the adult care safeguarding team, the allegation was substantiated.

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

Inadequate

Is the service effective?

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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. 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).

Applications to deprive people of their liberty with regard to freedom of movement had been made by the provider. They were awaiting a response from the local authority who were considering the applications for authorisation.

Staff were able to describe how people preferred their care and support to be carried out and their personal preferences. They helped people to decide what to wear each day for example, by putting out a choice of clothes where the person would decide or where the person could not make this decision, they would pick something in the colour which they knew the person liked. People had the freedom to get up and go to bed at the time they wished.

The staff we spoke with had varying levels of understanding about the MCA and DoLS. They were able to tell us about decisions being made in people's best interest but not about the process to do this. For one person there was no mental capacity (MCA refers to the mental capacity act) assessment in place or a best interest decision around supporting them with personal care. The care plan stated 'Act in X best interests. Due to X being unable to do this for themselves, Staff need to intervene and act in X best interest to ensure they remain clean, comfortable and free from infection'. We found no evidence of a support plan to manage this or guidance to staff.

Not all staff could describe what was meant by 'capacity' and the deputy manager told us they did not feel families should have to seek legal authorisation to make decisions on behalf of their loved one.

The MCA deems that everyone has the capacity to make decisions unless proven otherwise. There were four people where it was not clear to us if they had the capacity to make big decisions, either about their finances or their health and welfare. There were no capacity assessments for these people, firstly to establish what support, if any the person may require, and secondly that families who made the bigger decisions on the person's behalf, had the lawful authority to do so through a Lasting Power of Attorney.

At this time, the provider did not hold sufficient evidence that families had been granted an LPA and the reason. This information was therefore not incorporated into care planning documents to ensure people's rights were protected.

This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, staff undertook training on 03 December 2016 which included care planning, tissue viability, record keeping, pressure care and safeguarding.

Care staff undertook cleaning, laundry and cooking duties in the home in addition to their caring role. Staff told us they had completed training such as infection control, food hygiene, health and safety and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). However, through our observation of staff practice including the poor food hygiene in the kitchen, review of documentation and speaking with staff, some did not have the skill base in these areas to undertake the tasks safely and to support people in line with the MCA.

Upon speaking with staff we found some lacked awareness around supporting people with dementia. Particularly around communication and understanding cognitive impairment. One member of staff described people's behaviour as "When there is a full moon, people really kick off, quite irate behaviour". This is an opinion which has no factual basis of correlation to behaviour.

One person had recently moved into the home. They had a history of epilepsy. None of the staff had received training in epilepsy awareness to be able to support this person in the event of a seizure. The manager told us this person hadn't had a seizure for a long time. They failed to recognise that staff may not be able to support this person safely or recognise symptoms of a seizure and when this person may require support.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appraisals were completed annually to review staff training, learning and development needs. Staff told us they were supported to obtain further qualifications and had achieved or were working towards the Diploma in Health and Social Care and other relevant qualifications.

People were not supported to eat a healthy balanced diet. Care staff took on the additional role of meal planning, preparation and cooking. On the kitchen wall was a brief list of people's food likes and dislikes and any special dietary needs. To respect people's confidentiality, this information should only to be accessible to staff, however the kitchen was accessed by people and visitors.

Staff told us whichever member of staff was cooking that day, decided upon two meal options which people could choose from. There were no documents in place to evidence that meal planning was co-ordinated between the different members of staff cooking or over a period of time. There was no overview that people were receiving a balanced diet of proteins, fats, vegetables and fruit. The manager told us they did not have this in place and a member of staff told us "I just look in the freezer to see what there is and then decide".

The kitchen cupboards were stocked with tins of food including tinned fruit and packets of rice and pasta. The freezer held different types of processed meals and frozen meat. We saw there was no fresh meat or fish and a member of staff told us they didn't buy in fresh. People told us they had enough to eat although there was a mixed response about the quality and the variety of the food. Some people said the food was 'very good', 'delicious', 'ok' and 'it would be lovely to have a bit of fresh fish'.

One person required a specialised diet due to coeliac disease which is a disorder of the autoimmune system.

The person told us they did not enjoy their food as it was bland. In the kitchen was some information on the type of food this person could eat, however we found they were restricted in their choice due to a lack of understanding around a coeliac diet. Staff explained this diet to us as 'anything that doesn't have wheat in it'.

There was no management plan in place for this person's dietary needs which stated what they could eat and what should not be eaten, also how food should be stored to prevent cross contamination with products containing gluten. There was no information to guide staff such as, what substitute foods the person could have, food which could be available to them on prescription, recipes and supermarket branded foods which could be eaten.

People were not consulted about the menu selection and there were no written or pictorial menus in place. At lunch time staff told people the two dishes which were available, however this did not accommodate people who required a visual prompt to be able to select the dish they wanted. People were not involved in deciding what dishes were on the menu.

During our inspection we observed people during lunch time. On the second day of the inspection, people were sat in their armchair and ate from a small table in front of them, they were not asked if they would like to sit at the table. Staff did not clean the tables or place napkins and cutlery on them before serving the meal, firstly to ensure the table was clean but also to make the meal more of a social dining experience.

We observed two people did not receive appropriate support to eat and left their meal. Another person had two to three mouthfuls before they gave up trying to eat the meal. A member of staff was supporting one person to eat whilst trying to monitor another person who did not want to sit at their table. Another member of staff walked past one person who required support to eat, picked up the cutlery and gave the person a mouthful of food, they then walked away to carry on with the task in hand.

On the other days of the inspection some people sat at the table. This was a more positive experience as they chatted amongst themselves, laughing and appreciative of staff serving them at the table. We heard one person comment "well this is lovely sitting at the table". One person helped to put the napkins on the table and was pleased with their efforts.

Adaptive cutlery and crockery were not available to people to support and promote their independence with eating and drinking. Some people had heavy white bowls which they ate out of. We observed people were not able to easily move the dish or get food from it. One person got up and was holding their bowl. Had this person dropped the bowl it was heavy enough to cause them injury. We asked staff why people did not have lighter plates and they told us 'it hadn't been considered'. They also stated 'one person has a two handled cup but no other equipment is available'. People's support needs with eating and drinking had not been fully assessed to ensure people remained as independent as they were able to be.

People received drinks at set times and for people who ate their meal in their room, water and squash was available. However, no drinks were freely available in the lounge and staff did not ask people if they wanted a drink in between the set times. There were no jugs of squash or water readily available to ensure people had sufficient fluids. We reviewed people's care planning around hydration and in four care plans it stated it was important these people had good hydration.

We reviewed the fluid charts, some charts were not completed and there were no records of the total amount of fluids people had consumed that day, or of the optimum level of fluid the person required. Where fluids had been low for example, on the 29 November 2016 one person had taken only 440 mls of fluid, no

responsive action had been taken. The food and fluid charts were completed by the senior member of staff and these were kept in the locked cupboard in the dining room. Food and fluid charts were not kept where the person was sitting, for example in their room. This could lead to inaccurate food and fluid entries due to staff not recording at the time the person ate or had a drink.

We observed different approaches from staff in the way they supported people to eat and drink. One member of staff supported the person to eat, offered them a drink in between their food and patiently waited until the person was ready to eat another mouthful. However, they did not describe to the person what food was on the fork or if the person wanted something else from the plate. We observed another staff member supporting a person to eat, they did not make this event into an opportunity to communicate. The member of staff sat almost parallel to the person and gave them mouthfuls of food without any eye contact or conversation.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us "the doctor is coming this afternoon. I see the chiropodist from time to time and the optician has checked my eyes here". Other people told us the district nurse visited them and they could see a doctor when they needed to. Records demonstrated a chiropodist visited every six weeks.

Within the care records we found evidence that people had not attended health appointments. There was no rationale as to why this was, or of supplementary support which the person may require due to not attending the appointment. An appointment for a pacemaker review was cancelled, another person did not attend a diabetic eye screening they were offered.

Other people had not been referred to health professionals when required. One person had not been referred to the mental health team despite exhibiting behaviours of distress. An entry in the daily diary dated 29 November 2016 stated 'staff noticed when feeding and giving personal care to X, there was a purple colour on their neck, please observe'. There was no mention of medical attention or advise being sought.

This was a breach of the Regulation 09 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People were not always dressed appropriately to ensure they were warm and their dignity was maintained. Two people went into the lounge and did not have socks on but did have shoes on. One person was walking around in their socks, which was a trip hazard or risked damage to their feet without protection. On two occasions we saw the same person walking around on a dirty carpet without any socks or shoes on. On the second occasion they had their pyjamas on and asked if we could help them as they wanted to get dressed. One person was taken into the lounge area with a thin blouse on and no slippers. The member of staff continued to dress them in front of other people.

Not all staff communicated with people in a respectful way or protected people from unnecessary criticism. One person told the staff they wanted something to eat. With advancing dementia they had not remembered they had eaten breakfast. A member of staff responded by saying "You've just eaten something". This person became the object of a joke with a relative of another person joining in saying "stop moaning X, it's not dinner time yet. Bet you would like a nice fry up, bacon, sausage and eggs, you'll eat anything". The person replied "go on then" and their demeanour changed to become confused.

The staff member did not intervene to offer comfort to the person and to deflect the situation. They told the person "you are a fuss pot". Later staff gave the person a cup of tea and a slice of cake. Staff told us this person 'always asked for food'. This response demonstrated a lack of understanding around dementia and that people should be treated with dignity and respect at all times, whatever their personal characteristics.

During the inspection we saw a member of staff with one person in the lounge with the intention of undertaking a joint activity. We observed the member of staff colouring in a book but the person was being ignored by them. The member of staff carried on with the activity as if the person was not present or participating in the activity. There was no interaction from the staff or any eye contact. This meant the person was ignored, the activity was not meaningful and the experience was not positive.

At lunch time we witnessed one person got up from their chair and started to walk around. The member of staff raised their voice and firmly told the person "No, sit down" as if rebuking a child.

Throughout the inspection we witnessed people who were using the ground floor toilets shouting out for help. One person had the door open and could be seen sitting on the toilet. Staff told us this person would not wait for staff to come and would open the toilet door. Their response was 'this is what they [the person] always does'. We later heard another person shouting from the toilet "somebody help me" over and over again. We advised a member of staff and they told us "oh, X always does that". They did not go and see if this person needed help.

We discussed the incidents with the manager and provider and found no consideration had been given to supporting people to maintain their dignity and ensure privacy whilst using the toilet. Whilst the inspector and provider were walking through the downstairs hallway, one person was calling for help and left the toilet with their trousers around their ankles. The door to the toilet was not easily closed as the wood archive

around the door had expanded. Later that day, we tried to close the door from the inside however it needed a heavy slam to shut it, which most older people and those without physical strength would find difficult.

The window of the first floor toilet was visible to neighbouring properties and people who were in the back garden. A net curtain had been put up at the window, however did not reach the full length of the window leaving a gap at the bottom. People could be seen whilst using the toilet. This did not enable people, staff or visitors to have privacy whilst using the facility.

People's personal information was not securely locked away to ensure confidentiality and staff left care records unattended. In a cupboard in the quiet room we found a folder with care documents for one person and the cupboard was not locked or able to be locked. On the wall was a list of people's relatives with their contact details. Near to the medicine trolley, pinned to the wall was a completed prescription form with the person's name and details of the medicine prescribed.

At various times throughout the inspection, staff completed care records in the lounge. When staff left the lounge the records were left unattended on the dining room table. Visitors and other people had full access to these records.

During the handover between the day and night shifts, staff were recording details of important information in the daily diary. This diary contained personal information about people such as 'X urine very strong in smell' and 'X very vocal'. This information was recorded next to the day to day events of running the home, such as staff days off, rota details and 'bin done'. This did not ensure people's dignity was respected or of their personal information remaining confidential. This was because the book was used to record all events of the day and various people would need to have access to it.

Each person had an individual daily record where staff could enter relevant information. However, as staff were recording entries in the daily diary and not in this document, this meant important information was not in one place and therefore not readily available to assess and monitor people's care and support needs.

We reviewed the end of life care plans which were in place. These were brief and centred around the 'Do Not Attempt Resuscitation' forms. There was little information about people's wishes around how staff could support them should they wish to remain in the home at the end of their life. One person had an end of life care plan which stated 'Staff should spend time with X, one to one, providing company and comfort'. There was no further information about the level of support staff should provide and how they could provide company and support in the way the person wished. Throughout the four days of our inspection we heard this person shouting and screaming. We asked a member of staff why the person did this and were they in any pain. Their response was "No, they're not in pain, they always shout".

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were friendly and supportive. Comments included "I see the same carers every day", "staff are so caring" and "no complaints at all, staff do a good job. The carers in my opinion deserve the title of carer". Most relatives gave positive feedback about the staff with comments such as "carers are brilliant here, X is very tactile and loves her hugs from the staff", "every single one them, brilliant, consistent staff and all approachable" and "staff are thoughtful, nothing too much trouble".

People told us staff knew them well and were interested in them. Staff knocked on people's door before being invited in which ensured people had privacy. Relatives told us they attended assessment meetings

and were involved in setting up the initial care plans and staff informed them of any changes as necessary. We saw examples of positive interactions between people and staff and when staff were available they responded quickly to people's request for support.

Inadequate

Is the service responsive?

Our findings

The provider failed to ensure that people's care and treatment was personalised specifically for them and there was a lack of oversight in the care and support people were receiving. We reviewed people's care plans which documented their wishes around personal hygiene, such as taking a bath or shower. We reviewed the recording of people's daily care which staff completed and found when people had taken a bath or shower this was recorded against the appropriate day.

We asked people how often they had received a bath in November 2016 and two people told us they had, whilst others had told us they did not have a bath. This correlated to the bath water temperature recording in the downstairs bathroom which gave two dates.

We further reviewed the recording of people's daily care. In October 2016 there were fewer baths being taken than in September 2016. In November 2016, seven out of eight people had not received support to take a bath. In addition, it was clearly recorded for the morning and the evening that each person had received a strip wash and the 'bath' category was left blank.

We asked the manager if the recording was an accurate picture of the personal care people had received in November 2016. They told us 'no, people do have a bath when they want, it's just not recorded'. We asked the manager 'why are staff recording a morning and an evening strip wash if the person had a bath that day?' They did not respond to this but stated 'people are clean aren't they?' It was not clear from the records how often people had their hair washed or received nail care as many of these entries were blank. We discussed with the manager the fact that each person had a plastic bowl in the sink of their room. The manager did not know why this was and told us 'I don't think the bowls are being used to give strip washes'.

The care plans were not person centred as they lacked information about the person's preferences for their care and support. The care plans were task orientated and stated what staff must do rather than explain how staff could support the person to do as much as they could for themselves, for example how staff could support the person to use the wash basin and what elements of their care the person could contribute to and how long this might this take. This approach would enable people to maintain their independence for as long as possible.

People were not being supported with their continence needs to ensure they remained dry, clean and their dignity was maintained. The night handover in the daily diary dated 25 September 2016 stated 'faeces found in X commode, on seat and dried faeces on the floor'. This demonstrated that staff were not supporting people at a level they required. Another person who was doubly incontinent required support with their toileting. An entry in the night handover daily diary stated 'X care plan states toileting and pad changes need to be recorded day and night, why is no-one doing this?' This person did not have a continence care plan in place and as there was little recording of staff intervention, we were unable to ascertain if this person did receive the support they required.

Monitoring of people's health needs were either not being done or not to the required timescale. The charts

in place for repositioning people to prevent pressure damage were unclear because they did not specify how often the person should be repositioned. There was no evidence that people who sat for long periods of time were being monitored to ensure they were supported to be repositioned. We observed that people were sat in the lounge for most of the day and were not encouraged to move about, for example to a different chair.

On person did not have an assessment for the use of a crash mat in case of a fall. A decision was made not to weigh the person due to failing health, however nothing else was documented about how staff could determine the person's weight and therefore health. The moving and handling risk assessment had not been reviewed since September 2016 and this was a continued need. The person was at risk of dehydration and no assessment had been completed since September 2016. There was a lack of detailed information about a pacemaker, such as when it was fitted and what action staff should take to minimise the potential of harm to the person, such as not standing too close with a cellular telephone. as may impact on how the pacemaker worked and subsequently the health and welfare of the person.

Another person had specific needs around the management of their diet and weight reduction, however the daily records did not mention specific dietary monitoring.

Several people in the home were not able to verbalise their opinion and there was a lack of information as to how they communicated, for example eye contact, objects of reference, facial expressions. One person's care plans stated 'gets words muddled' but no other description of how this presented and what action staff needed to take to ensure the person was able to communicate their wishes when they got their words muddled. Another person vocalised through using different sounds and phrases and we found no guidance as to what the pitch or tone could indicate the person was communicating.

There was little information in people's care planning as to how staff could involve them in their care. For one person, staff were not able to tell us how they knew the person was in pain or distressed. There were no pain management plans in place for any of the people living at the home which meant staff were not being responsive to their needs at these times.

For people who were funded by the local authority for their placement at the home, a review was carried out on an annual basis. The manager told us they did not carry out any other review which involved family and the person. However, they did complete a monthly review of the support plans for each person. We looked at a sample of monthly reviews and found some months where the care had not been reviewed. In addition, each of the records had a similar statement 'no changes' and these were over a long period of time. For one person it stated they were chair bound, however this status had changed six months previously yet the monthly review stated 'no changes'. This demonstrated that people's care and support needs were not being adequately reviewed in order to meet their changing needs.

We reviewed the care records of three people and found at the front of each folder was the documentation from the previous placement the person had lived at. We asked the manager about these who told us they did use the information whilst the person moved into the home. One person had recently moved into the home and their care records contained historical records from another provider. Two other people who had been living at the home for over a year also had historical records from another provider in their documentation. This practice is unsafe because staff may take information from the historical record as a description of the person's current needs. To ensure that people received appropriate care and support which meets their current needs, care records should be relevant and current.

The service did not have a dedicated activities co-ordinator in place and individual care staff took on this

role. People and relatives told us there were not enough activities going on because the staff had such a lot to do. People were not consulted or enabled to decide upon the activities or events they would like to do. There was no weekly or monthly activity planner in place or information about what people could do that day or look forward to. The provider told us they did not do this, because when activities were organised, people would often not want to take part. This resulted in care staff who were already stretched in their role, providing ad hoc activities when time permitted. One person said to a member of staff they wanted to go out for a walk, whereby the staff member responded "you went out yesterday".

There was a lack of stimulation for people, especially those who were confined to their room. People who had received an assessment of their care needs through the local authority had quite specific goals regarding their social stimulation and the provider was not meeting these needs. The activities which people took part in were documented, however this was brief, did not say how long the activity was for or how the person benefitted from the interaction.

There was no recording for activities after the date 21 November 2016. In one week the person had three days of no interaction, two days of 'family time' and the remaining two days were 'massaged hands' and 'listened to music'. This person was bedbound and at end of life where interaction was recorded as part of their end of life support plan. Another person had most days documented as 'walking around happy' and 'walking around with comfort doll'. Other people had participated in a session of bingo, music time or played games, however the activities recorded were sparse.

During the inspection we observed some activities taking place, a member of staff played a 'remembrance game' where the person would throw a small bean bag onto a board. They were then asked the question where the bean bag had fallen. This was about the work people used to do. People enjoyed this activity and it prompted discussion, laughter and questions. One person said "I really enjoyed that, I'd like to do that again". There was also a sing-along in the lounge to choir music and people who were able to join in really seemed to enjoy it, however, for people who could not join in they were left out of this activity and nothing else was put in place to engage with them.

This was a breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they had not received any complaints within the last year. We reviewed the documents held by the service and there were no complaints or records of informal complaints. People and families told us they would speak with the manager if they were not happy about something and this was usually resolved quickly.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was not a registered manager in place. The previous deputy manager had applied for the position of manager and was successful. They intended to make an application to the CQC to become the registered manager.

People told us they knew the manager well and that they were approachable and always about. Relatives were positive about the way the home was managed and felt it was a 'homely place and people were well cared for'. Staff told us they felt valued by the manager and felt it was an open culture.

The provider did not have effective systems or processes in place to ensure compliance with the requirements of good governance. They failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others which arise from the carrying on of the regulated activity.

The provider told us they completed quarterly visits to the home to carry out audits and quality assurance checks. We were given copies of the September, October and November 2016 'Provider Observation Report' completed by the provider. Each of the monthly report gave the same information with one or two changes. None of the concerns and the shortfalls we had identified during the inspection had been recognised by the provider and subsequently they had failed to put an action plan into place. This demonstrated the provider did not have the relevant skills and knowledge of the requirements of the fundamental standards of care as a minimum standard they should achieve.

There was a lack of general maintenance around the home to ensure it remained clean, safe and appropriate for people to use. On the first day of the inspection, we asked the manager if they had a maintenance book we could look at to establish what repairs had been carried out, what had been identified as requiring repairs and actions taken as a result. They told us they could not find the maintenance book. On the last day of the inspection, the manager provided us with a copy of a maintenance schedule for the home. This document was not dated and although highlighted some areas which required repairs did not reflect the range of concerns we found. The provider could not evidence they had carried out continuous assessment and improvement to the environment and other areas.

The manager was responsible for completing the quarterly audit tool, this was a comprehensive document which listed areas such as information, quality management, treatment and support, medication, safeguarding and the environment. The manager's assessment of the quarterly quality audit dated 01 November 2016, did not highlight shortfalls in the environment, safeguarding, medication, quality management and other areas.

In the providers audit pack were sheets where 'outstanding issues or action plans' for 'external visits and internal/provider visits' could be completed. These sheets were blank and there were no actions carried forward from previous months. When completing the audit, the manager had documented that items were correct when this was not the case. For example, they stated that for each person who lacked capacity there was evidence of best interest meetings and stated this was available in the care plans. This was not the case

as not everyone who may be eligible had been assessed for their understanding around consent to care and treatment and financial matters.

Medication errors had not been identified and the reviewer considered the shed/outbuilding was safe where it was not, as our visit found it had deteriorated over some time.

The auditing process did not provide an overview of people's changing care and support needs. The manager was not able to provide us with information on the first day of the inspection which gave a summary of the current needs of people. For example, people who may be at risk of dehydration and malnutrition, behavioural concerns, pressure ulceration, sensory impairment, mobility issues and dietary needs. The manager provided this information two days into the inspection. They told us they had not previously collated this information, however they would do so in the future.

The provider stated in their quality assurance report of 2015 that it had been a difficult year due to the local authority not increasing their fees and an increase in the national living wage. They stated 2016 would continue to be an 'even more difficult year' for the company and they would 'make as much improvement to the environment as possible for the comfort and safety of the residents and staff'. The provider told us they had made some improvements to the home, with new carpets in people's rooms, a new carpet for the lounge soon to be fitted and the purchase of new curtains for the lounge. Following the inspection the provider gave us assurances that the service was financially viable.

We asked the provider to supply us with a copy of the development plan for the home to ascertain if they had an overview of the environment and safety with timed and planned changes being made and according to priority. They did not provide this document. From the documents we looked at such as the 2015 quality assurance and the maintenance log we found repairs and improvements to the home were happening without any planning or forethought to identify risks, for example the provider had stated their next improvement was to fit a wet room, however had not prioritised areas of real concern around safety.

This was a breach of Regulation 17, Good governance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider has a responsibility to be aware of the notifications which must be submitted to the Care Quality Commission as part of their registration. The provider failed to do this as required. The provider did not notify the CQC through a statutory notification regarding a safeguarding concern in respect of a person who lives at The Haven. We were contacted by the Mental Health safeguarding team to advise us of their concerns.

This was a breach of Regulation 18, Notification of other incidents properly. Care Quality Commission (Registration) Regulations 2009.

During the inspection the provider told us the lift between the ground and first floor had not been in operation for four days during September 2016. This was because of works which needed to be carried out on the lift. This affected one person whose accommodation was on the first floor and who were not mobile. The provider failed to notify us through a statutory notification as required and to provide an explanation of what action they would take to minimise the risks to people of not being able to reach the ground floor. In addition, how people's care and support would be affected and what steps they had taken to ensure provide the same level of care and support.

This was a breach of Regulation 18, Events that stop the service running safely and properly. Care Quality

Commission (Registration) Regulations 2009.

The provider failed to notify the CQC as required. There was a change in the person other than the registered manager managing the regulated activity. The intention of this regulation is to ensure CQC is notified of specific changes in the running of the service, so that CQC can be assured that the provider has taken appropriate action.

This was a breach of Regulation 15, Notice of changes. Care Quality Commission (Registration) Regulations 2009.

The provider had failed to update their Statement of Purpose and it contained inaccurate information. At the inspection in December 2016 we requested that the provider update this document. We received the revised document on 13 December 2016.

Schedule 3 of the Care Quality Commission (Registration) Regulations 2009 states that the Statement or Purpose must contain five pieces of information, one piece of information relates to section 3 which states: information is required in relation to the service provider and any registered manager, their business address, business telephone number, electronic mail address where available.

In addition, information in relation to the registered person should include: The address to which the Commission may send any document, notice or any other communication required to be delivered by these Regulations or the Act. And, where the registered person consents to the service by such means, an electronic mail address to which the Commission may send any document, notice or other communication required to be delivered by these Regulations or the Act. The provider had not updated their Statement of Purpose to include the information as required.

This was a breach of Regulation 12, Statement of Purpose. Care Quality Commission (Registration) Regulations 2009.