Sun Healthcare Limited

Havenfield Lodge

Inspection report

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Date of inspection visit:
10 July 2017
12 July 2017

Date of publication:
28 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 12 July 2017 and was unannounced on the first day and announced on the second day. The service was last inspected on 25 November 2015. At that time the service was not meeting the regulation related to staff training. At this inspection we checked to see if improvements had been made.

Havenfield Lodge is a nursing home registered to provide accommodation and nursing care for up to 46 people who have a learning disability and/or autistic spectrum disorder and/or physical disability. There is a separate flat within the home shared by three people with its own staff. At the time of this inspection 36 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at Havenfield Lodge.

Medicines were not always managed in a safe way for people because topical creams were not recorded as being administered, or checked to ensure they remained within their expiry date and were therefore effective. Some people did not have 'when required' protocols in place and medicine was not always administered in line with National Institute for Clinical excellence (NICE) guidelines.

There were adequate staff on duty to meet people's assessed needs, although staffing was not always based on assessing each person's levels of individual need or dependency. We have made a recommendation about considering the use of a dependency tool to allocate staff according to people's individual assessed need for support.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse.

Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence, although we saw one person had no risk assessment in place for bed rails.

Effective recruitment and selection processes were in place.

Staff had received an induction and received occasional supervision. We found staff training was not always up to date and so we could not be assured staff had the knowledge and skills to support people who used the service. We found similar concerns at the last inspection in November 2015.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, people's mental capacity was not always considered when decisions needed to be made and evidence of best interest processes was not always available.

People's nutritional needs were met and they had access to a range of health professionals to maintain their health and well-being, although one person was not supported to have their health needs met in a timely manner.

Staff interactions were caring and there were good relationships between staff and people using the service. Staff knew how to support people in a way that maintained their dignity and privacy, although we saw two examples where people's privacy and dignity were not supported.

Staff promoted people's independence, however, there was limited opportunity for people to sustain or develop independent living skills.

People and their representatives told us they were not always involved in planning and reviewing their care. Care plans contained enough information for staff to deliver person-centred care, although some information had not been updated. People's needs were usually reviewed as soon as their situation changed.

Whilst most people engaged in social and leisure activities which were person-centred this was not at a level which would meet the needs of all the people using the service. We found there was a lack of interaction for one person with complex needs.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were approachable.

The system of audit and oversight used by the registered manager was not effective in identifying and addressing the issues we found. Robust action had not been sustained regarding staff training to ensure staff had the skills and knowledge to deliver effective care.

Records were not always up to date and there were gaps in daily recording for some people.

The registered provider had an overview of the service. They audited and monitored the quality and safety of the service but this system had not identified and addressed the issues we found.

People were positive about the registered manager and the culture of the organisation was open and transparent. The management team were visible in the service and knew the needs of people who used the service.

The registered provider used surveys to gain feedback about the service provided and the results of these were acted on.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

Medicines were not always managed in a safe way for people.

Staff had a good understanding of how to safeguard people from abuse.

Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

There were sufficient staff on duty to meet people's assessed needs. Recruitment procedures were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received sufficient training and supervision to enable them to provide effective support to people who lived at the home.

People's mental capacity was not always considered when decisions needed to be made.

People were supported to eat a balanced diet and had access to external health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff interacted with people in a caring and respectful way.

People were usually supported in a way that protected their privacy and dignity; however, we saw two examples where people's privacy and dignity was not considered.

People's independence was encouraged; however, there was limited opportunity for promoting independent living skills at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans contained sufficient and relevant information to provide care and support; however, some information was not up to date.

People were supported to participate in activities both inside and outside of the service, although we saw there was limited social interaction for one person with complex needs.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Accurate records were not always kept.

Quality assurance systems were in place, but had not identified and addressed some of the issues we found.

Staff and people were positive about the registered manager, who was visible within the service.

Havenfield 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 10 and 12 July 2017 and was unannounced on the first day and announced on the second day. The inspection was conducted by two adult social care inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector conducted the second day of the inspection.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team and commissioners. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

Some people who used the service communicated non-verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time with them observing the support people received. We spoke with 13 people who used the service and one relative. We spoke with three support workers, two senior support workers, two nurses, the registered manager and the cook. We looked in the bedrooms of five people who used the service, with permission. We received feedback from one community healthcare professional.

During our inspection we spent time looking at five people's care and support records. We also looked at three records relating to staff recruitment, training records, incident records, maintenance records, feedback from people and a selection of the service's audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Havenfield Lodge. One person said, "I feel safe living here. The staff are good. If I have any concerns, I can talk to all of the staff and they listen." Another person said, "I get my medication on time every day." A further person said, "Yes, I feel safe here. There are enough staff on, and nurses. I get my tablets when I should." And another person said, "It's a good place to live and I feel safe. I think there are enough staff here."

The registered manager told us the nurse on duty administered medicines and senior care staff were currently training in medicines administration in order to support with this. One person was assessed as having the mental capacity to administer their own medicines following a risk assessment.

We looked at how staff administered prescribed creams. One staff member told us they signed topical medication administration records (TMARs) in people's rooms and these were attached to their wardrobe. In seven people's rooms we found topical creams which were not dated upon opening, some of which had been dispensed in 2013 or 2014. This meant the creams may not remain effective. Some of these were unlabelled and without instructions for staff.

Two out of four creams in one person's room had no TMAR or cream chart to evidence their administration and three of the four were not dated upon opening. This person used topical creams due to the high risk of pressure damage to their skin. In a second person's room three out of six creams were not recorded on a TMAR and one additional cream had been prescribed for a different person. The nurse on duty removed some of the creams immediately and the registered manager told us he would address the concern. On the second day of our inspection we saw cream charts were in place. Following our inspection the registered manager told us he was developing training in the administration of creams for staff.

People's medicines were stored safely in secure medicines trolleys in a locked medicines room.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. However, we observed the nurse on duty signed medicines administration charts (MARs) before administering medicines on several occasions. This is not in line with National Institute for Clinical Evidence (NICE) guidelines. This meant there was a risk the medicine may not be taken, for example, if a person refused the medicine, and the record would show it had been taken as prescribed.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. The registered manager told us senior care staff provided the second signature in the controlled drugs register for the administration of controlled drugs if only one nurse was on duty, although they had not received training in medicines administration. We saw one of the three entries we sampled in the controlled drugs register was signed by one nurse with no second signature. This meant these medicines were not always administered in line with legislation and guidance. The registered

manager told us he would address this with the nursing team immediately.

We observed one person asking for pain relief at 9.00am during the medicines round; they received it one and a quarter hours later. The time recorded by the nurse on duty was earlier than the time the pain relief was seen to be administered which presented a risk of harm as the medicine had to be administered at specific time intervals to remain safe. This meant medicines were not always administered in a safe way for people.

Medicines care plans contained detailed information about medicines and how the person liked to take them, however, some people did not have individual 'when required' medication care plans For example, one person did not have a 'when required' care plan for Paracetamol. 'When required' care plans provide guidelines for staff to ensure these medicines are administered in a safe and consistent manner. The same person had a care plan in place for a medicine that was no longer given 'when required' but was now prescribed twice daily. This meant information was not always clear for staff.

The above issues meant people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for their management.

We saw only three out of nine nurses' competence in giving medicines had been assessed in the year prior to our inspection. The registered provider's medicines policy did not state the frequency medicines competency assessments should be completed as advised by Royal Pharmaceutical Society guidelines. This meant we could not be assured people received their medicines from people who had the appropriate knowledge and skills.

The above issues were a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us senior care staff and nurses at the home were currently completing a level three medicines management course through the local authority, and senior care staff would be able to administer medicines following this. Their competence would also be assessed externally.

We found all of the boxed medicines we checked could be accurately reconciled with the amounts recorded as received and administered. A stock check of boxed medicines kept on the trolley was completed twice daily by the nurse on duty and the night nurse on duty completed a check of each individuals 'when required' stock (kept in the medicines room) every three or four days. This meant the service had a system of medicines governance in place.

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One staff member said, "If I was concerned about bad practice I would report it to the nurse or the manager. If it was the manager I would go to head office to (name of director)." We saw information around the building about reporting abuse and whistleblowing.

We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and the Care Quality Commission (CQC) had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

The members of staff we spoke with understood people's individual abilities and how to ensure risks were

minimised whilst promoting people's independence. In people's care records we saw comprehensive risk assessments to mitigate risk in areas including sleep and rest, behaviour that may challenge, choking, physical health, hygiene, falls, finances, medication, and mobility. Risk assessments were also in place for people living with specific health conditions such as epilepsy. We saw safe moving and handling and falls risk assessments contained detailed guidance for staff to support people to reduce risks, for example, when transferring people using a hoist.

Most risk assessments had been reviewed regularly, were signed and up to date. However, following an incident of bedrail entrapment a specialist 'cradle' insert to a person's bed had been purchased to prevent further incidents. We saw this person's bed rail risk assessment was blank. This meant it was not clear how risk had been assessed to ensure the restrictions were proportionate to the risk of harm.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. Incidents and accidents had been recorded and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw action was taken following incidents or accidents to reduce future risks, for example, following on incident of behaviour that challenged, a review of the person's needs was requested with the multidisciplinary team and frequent observations were put in place to keep others safe. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety of the service.

A call system was in place around the building which people could use to summon staff assistance if needed. The registered manager told us call bell response times were not currently recorded and the registered provider was looking into this in order to monitor responses. One person with very restricted movement had specialised assistive technology which they used to summon staff assistance when in bed.

People told us there were not always enough staff on duty. One person said, "We are short staffed. It happens quite a lot. Today isn't so bad, but other days there just doesn't seem to be enough staff for people's needs." Another person said, "I feel safe here. It's a nice environment. The Staff are nice but they're always busy. I just want to talk to people but there aren't many in here that I can talk to."

One staff member told us there were enough staff on duty and staff picked up extra shifts to cover for sickness if required. A second staff member said recently they had been short of staff due to sickness and occasionally this could impact on people's activities, but agency staff could be used. A third staff member said, "When there are less staff you don't get time with the residents."

One nurse was on duty at night and two nurses were on duty during the day. We looked at historic rotas and saw on 25 June and 3 July 2017 one nurse had been on duty during the day. At these times all nursing tasks for the whole service would need to be completed by one person, although the registered manager told us he and the deputy manager were able to help out at these times. On the first day of our inspection one nurse was present in the building during the morning, and whilst most people's needs were met in a timely manner, we saw one person waited over an hour for pain relief. The registered manager told us he would address this with the nurse on duty.

The registered manager told us staffing levels had been set within the home over time and he did not use a dependency tool, although two people who used the service were allocated staff according to their assessed need for one to one support. Dependency tools are used to generate the number of staff required to meet people's needs by calculating the amount of support each individual needs daily and adding it together. We recommend the service seek advice and guidance from a reputable source about use of a suitable

dependency tool to deploy staff according to people's assessed needs.

The provider had their own bank of staff to cover for absence and asked permanent staff to do extra shifts in the event of sickness. Regular agency staff were also used. This meant people were normally supported and cared for by staff who knew them well. Managers were on call out of office hours to support the nurse on duty if required

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people.

People had detailed personal emergency evacuation plans (PEEPs) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. Fire drills occurred regularly and the staff we spoke with knew what to do in the event of a fire or if the building needed to be evacuated. This showed us the home had plans in place in the event of an emergency situation.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing. Checks had been completed on fire safety equipment and fire safety checks were completed in line with the provider's policy. A series of risk assessments were in place relating to health and safety.

One person had a grab rail in their room to support them to stand up. Their care plan indicated they liked to use the furniture in the bedroom for support and the person told us they preferred this to using the grab rail. We found the large chest of drawers the person used was not fixed to the wall, which presented a risk of injury to the person. The registered manager told us the person now routinely used the grab rail, however, they fixed the chest of drawers to the wall immediately following the inspection.

We found the building was generally clean and personal protective equipment (PPE) was available for staff to use. One of the communal toilets on the upper floor had no hand basin in place. This could present a risk of infection to people using the service. There was mal odour in a second communal toilet, which had three stalls for people to use and contained some used urine bottles. We spoke with the registered manager and he told us these toilets were already planned into the refurbishment schedule for the building and every person had a sink in their bedroom to wash their hands. They told us they would ensure infection control measures were monitored robustly.

Requires Improvement

Is the service effective?

Our findings

People told us they were confident the staff team at Havenfield Lodge could meet their needs. One person said, "I'm happy with the care and support I receive. The staff always seem to know what they're doing. They do to me anyway. I've no complaints."

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 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.

Most staff at the service had recently completed training and had an understanding of the MCA. One staff member said, "Some people lack capacity to make the right decisions. We explain decisions to be made."

We asked the registered manager about the MCA and DoLS and he was able to describe to us the procedure he would follow to ensure people's rights were protected. We saw 11people were subject to DoLS authorisations with no conditions attached, one person was awaiting authorisation and one person was awaiting an assessment for renewal. Twenty-three further people were considered to have the mental capacity to decide to live at the home.

We saw in the care records we sampled mental capacity assessments had been completed for some people in relation to the decision to live at the home, for the use of a PEG feed to support nutrition, for covert medicines, and charitable donations. In two records we sampled where bed rails were in use and records indicated the person may lack mental capacity to consent to certain decisions we found no mental capacity assessments had been completed. No mental capacity assessments had been completed in relation to consent to the administration of medicines for any people who may lack mental capacity to consent to the decision.

One person had signed a behavioural agreement and the record stated it was unknown how much the person understood about the agreement. A mental capacity assessment was not completed to explore this and ensure the person was able to consent.

The above issues meant the rights of people who used the service were not always protected in line with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11(1) and (3) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us he had spoken to the relevant people when making decisions in the best interests of people who used the service and they would ensure mental capacity assessments and best interest discussions were recorded. The registered manager completed a list of people who may lack the mental capacity to make certain decisions by the second day of our inspection and intended to complete the required assessments with them and their representatives.

Care plans and incident records showed physical intervention was only used as a last resort where harm may come to the person concerned or to those close by. Staff we spoke with were able to describe de-escalation techniques and how they minimised the use of restraint. This meant the human rights of people who used the service were protected.

At our last inspection in November 2015 we found the service was not meeting the regulation relating to staff training, because not all training was up to date. At this inspection we found not all staff had been provided with training and support to ensure they were able to meet people's needs effectively. One staff member told us their training had "touched on" epilepsy, dementia and supporting people with behaviour that may challenge others.

At this inspection we also found the numbers of staff requiring training in specific areas remained largely the same as at the last inspection and there was no evidence effective action had been taken to address this.

We saw from the training matrix none of the nurses or senior carers had completed annual medicines training in line with the registered provider's policy since 2015. Additionally, two of the nurses had not completed the three yearly training delivered by the pharmacy in the last three years as required by the registered provider's policy. The registered manager told us all nurses and senior carers were currently undertaking an external medicines training and competency assessment. However, this meant limited action had been taken to ensure medicines administrators remained up to date with training following our last inspection in 2015. This meant people may not have received their medicines from people who had the appropriate knowledge and skills.

The training matrix showed only 12 out of 49 care and nursing staff had completed 'positive behaviour support' training in the last three years to help them to effectively support people whose behaviour may challenge others. We found 24 care and nursing staff out of 49 had not completed emergency first aid. Nineteen out of 37 care staff had not completed epilepsy training. This demonstrated people were not always supported by suitably qualified staff with the knowledge and skills to fulfil their role.

In addition, we found 16 staff had not completed dignity and respect training out of a total 61 staff (including ancillary staff). Thirteen out of 49 care and nursing staff required fire awareness training and 12 staff out of 61 had not completed health and safety in the last three years. The matrix showed nine out of 49 care and nursing staff were not up to date with moving and handling, 13 out of 49 were not up to date with MCA/DoLS training and 11 out of 49 had not completed safeguarding adults.

The staff training matrix was not up to date which made it difficult for the registered manager to keep an overview of staff training and development needs. Some staff who had completed three-yearly infection control training in 2013 were marked as up to date on the matrix, but their training had expired in 2016.

The above issues were a continuous breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ten out of 37 care staff and one out of eleven senior care workers (including nurses) had completed food hygiene training in the three year timescale set by the registered provider's training policy. The registered manager had arranged infection control and food hygiene training for all staff to attend prior to our inspection and following our inspection showed us all staff were now up to date. We found nurses had recently been supported to complete training in tracheotomy and catheter care.

Following our inspection the registered manager sent us an updated training matrix and showed us the training that was now planned to take place. They also gave training booklets to some staff members to update their training in specific areas.

We saw evidence staff completed an induction programme when they commenced employment at the service, which was provided by the local authority. We asked three staff what support new employees received. They told us new staff completed induction training and shadowed a more experienced staff member for around a week before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. This demonstrated new employees were supported in their role.

One staff member said, "I definitely feel supported. I had supervision a few months ago. [The registered manager] does the appraisals." Another staff member said, "Yes definitely supported. The home is well-led. I have never had a supervision or appraisal."

We sampled three supervision records and found supervision was not always delivered in line with the registered provider's policy of four times a year, including one appraisal. One staff member had completed a seven day induction at the service in June 2016 and had supervision in August 2016, but none since. This meant staff did not always receive management supervision to monitor their performance and development needs. The registered manager showed us he was addressing this and 26 staff had received supervision in May and June 2017 and further supervision was planned on the rota for July. Staff supervisions covered areas of performance and also included the opportunity for staff to raise any concerns or ideas.

Staff told us communication was good. Two detailed handovers a day were held between shifts and a daily handover sheet for each person was used, as well as a communication book to share information such as health issues, activities and incidents or concerns.

One person said, "The food is good. There is a good choice. We don't have the same thing every day. We don't just have chips; we have mashed potatoes and jacket potatoes some days." Another person said, "The food is alright and there is enough for me. I get a choice. I'm quite content here."

People told us they enjoyed their meals and could choose what they wanted. Meals were planned around the tastes and preferences of people who used the service. Pictorial menus were on display. We heard staff offering a person who used the service a choice of meal and we saw they received the meal and drink of their choosing. Each person had a list of food likes and dislikes in their care records which were used to inform meal planning.

We saw staff asked permission before supporting one person to use a tabard to maintain their dignity during lunch. Staff were patient with another person who needed assistance to eat and chatted with them and encouraged them during their meal. We saw staff waited until people had finished their meals before asking permission to remove the plates and clean the tables.

We observed some people helped themselves to a drink and snacks, and drinks were offered to people

throughout the day. Three people shopped for and cooked their own meals with staff support in a separate unit.

We saw one person was not encouraged to eat in line with their care plan during their evening meal. The staff member spent three minutes with the person and did not encourage the person to eat when they indicated refusal. The person was not seated in the way suggested in their nutrition care plan to encourage optimal uptake of nutrition and fluids. This was a missed opportunity to support better nutrition for the person, who was at risk of weight loss. On this occasion the staff member did not inform the person what the meal was or provide any sort of choice. We discussed this with the registered manager who told us he would address this with the staff member.

One person said, "I can't have too much sugar in my food and drink as I have to be careful for medical reasons and the staff make sure that they give me healthy food most of the time."

We saw the individual dietary requirements of people were catered for, for example, some people had meals of specific consistency following advice form the speech and language therapy team. The cook had a file in the kitchen with people's special dietary requirements and tastes. People were weighed weekly to keep an overview of any changes in their weight and we saw advice from the GP or dietician was sought if required. This showed the service ensured people's nutritional needs were monitored and action taken if necessary.

Meals and drinks were recorded in people's daily records, and fluid intake was also recorded if the person was at risk of poor fluid intake. We saw for one person no fluid was recorded as offered or taken between 4.30pm on 7 July 2017 and 9am on 8 July 2017. The person was recorded as in bed at supper time; however, it was not clear from records if any fluid had been offered between that time and the next morning. The registered manager told us staff told him they had offered drinks, and he would continue to speak to staff about recording whenever food or drink was offered, even it was declined.

One person said, "If I need to go on a doctor's appointment, or a hospital visit then I'm supported there by the staff. Those that can't walk are taken in the minibus but we often get the bus there."

People had access to external health professionals as the need arose. Staff told us systems were in place to make sure people's healthcare needs were met. Staff said people attended healthcare appointments and we saw from people's care records a range of health professionals were involved. This had included GPs, psychiatrists, community nurses, chiropodists and dentists, speech and language therapy and psychologists. This showed people who used the service usually received additional support when required for meeting their care and treatment needs. We saw one person had complained of toothache from 7 July 2017 and a dental appointment was not requested by staff until 10 July 2017. The person was still complaining of pain on the first day of our inspection and was dependent on staff for all health care needs. On the second day of our inspection the registered manager showed us the person had attended the dentist on the day after the inspection.

We saw the service was spacious and comfortably furnished. There were pictures, art and craft work completed by people who used the service and photographs and sensory items in the communal areas. Only two people had en-suite facilities; all other toilet and bathroom facilities were communal. We found there was a malodour in one of the communal toilets, which contained three toilet cubicles. The window frames were also deteriorated in places. The registered manager showed us this was due to be refurbished in the very near future, which would ensure the building was safe and suitable for use.

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought the staff at Havenfield Lodge were caring. One person told us, "The staff are nice. [Name of staff] gave me a nice bowl of porridge for breakfast this morning." Another person said, "They always knock before coming into my bedroom and they ask before they do anything. I wouldn't like it if they just did something without asking first." A third person said, "I do like the staff but I also like my own company."

One relative said, "The staff are excellent. I can't complain about anything. I used to be concerned when [my relative] first moved in but I'm not anymore. Even when I'm in the room with [my relative] the staff are always popping in and asking if we want any tea and biscuits."

People who used the service told us they liked the staff and we saw there were warm and positive relationships between people. Staff we spoke with enjoyed working at Havenfield Lodge and supporting people who used the service. One staff member said, "I like making a difference to people. I've made that person smile. It's very rewarding helping a person to achieve what they wanted to achieve." Another staff member said, "The residents make your day." A third staff member said, "I love it. The residents are lovely. You tend to get a bond. It's rewarding, making a difference."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities. They used this knowledge to engage people in meaningful ways, for example, by engaging them in conversations about activities or playing music they knew the person liked. There was banter and laughter between people and a friendly atmosphere at the service.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw one person was reassured in a kind and supportive way when being supported to transfer.

People were supported to make choices and decisions about their daily lives. Staff used speech, gestures and facial expressions to support people to make choices according to their own unique communication style. Staff told us people had a choice of activities, when to have a bath or shower, what to eat and what time they went to bed and got up.

Staff told us people or their representatives were involved in their care plans and reviews. Some people told us they were involved in planning their care; where this was not possible or not desired by the person their family, an advocate and other relevant health and social care professionals had been involved. Some people told us they were not involved in planning their care.

People appeared well groomed and looked cared for, and chose clothing and accessories in keeping with their personal style. We saw staff knocked and asked permission before entering bedrooms. Staff told us they kept people covered during personal care and ensured doors were closed. We observed some people who used the service had their own bedroom door key in order to lock their bedroom door if they wished to

do so.

A notice board was on display about promoting people's dignity and the dignity champions that had been appointed at the home. However, one staff member we spoke with referred to people who required supporting to eat as 'feeders' and we discussed the way in which this could be considered to be a derogatory term. The staff member said they did not like it, but it was the way people were referred to at the service, although only one staff member used this term during our inspection. The manager said they would address this with staff.

We saw one person had a sign attached to the outside of their bedroom door for staff regarding their personal care, which did not respect the person's right to privacy and compromised their dignity. We discussed this with the registered manager who told us he did not know this sign was present and removed it straight away.

People had personalised their bedrooms to reflect their tastes and interests and chosen their furnishings and décor where possible. Personalising bedrooms helps staff get to know a person and helps to create a sense of familiarity; it also make people feel more at home.

Some people were supported to maintain and develop their independence skills. Three people who lived in a separate unit were supported to take part in meal preparation. A small number of people who lived in the main part of the home attended the local college with the activity coordinator and completed training in cooking and independent living skills. However, there was no opportunity for them to maintain or improve these skills at the home. Two staff members told us they used to support some people to prepare their own meals in a kitchenette on the main unit to improve their independent living skills, however, they were no longer given time to do this. One staff member said, "They don't want to cook. Some take their laundry down. No one helps clean their room. We have tried to encourage them." The registered manager told us he would look for ways to promote people's independent living skills within the service.

One staff member told us people did not take part in doing their own laundry, but some people liked to strip their bed, tidy their room or help make hot drinks. Another staff member told us they encouraged a person to use the spoon themselves when eating and prompted people to do whatever they could for themselves. Care plans detailed what people could do for themselves and areas where they might need support.

Staff were aware of how to access advocacy services for people if the need arose and some people had an independent mental capacity advocate (IMCA). An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves. We found one person who was unable to advocate their own needs did not have family involvement or an advocate and was awaiting the renewal of their DoLS application which meant they no longer had an IMCA allocated. The registered manager told us he had followed this up with the local authority and would continue to do so.

People and their representatives had been consulted regarding end of life plans and wishes, where appropriate, and these were recorded. We saw from care plans there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions where they were in place.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with said, "The Staff know how I like things done. They know that I like sugar in my tea and how I like things to be cooked."

A relative told us, "If I thought the staff weren't doing their jobs properly I would complain. The only care plan really is that the home takes care of [my relative]. I haven't really discussed it with them. I'm confident that [my relative] is in good hands here."

We found care plans were person centred and explained how people liked to be supported. For example, entries in the care plans we looked at included, "My hair is kept short." This showed the service responded to the needs and preferences of people who used the service.

Care plans were detailed and covered areas such as communication, mood and cognition, wheelchair use, personal safety, medication, sleep, social skills, physical health, finances, education and recreation. Care plans were also in place for specific health conditions. Where needs had changed these had been updated in the care plans we sampled and a monthly action plan had been completed. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage.

Care plans contained information about people's individual behaviour management plans, including details of how staff would care for people when they exhibited behaviours that challenged, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

We found examples where some information was out of date. For example, we saw one person's hospital passport had been completed in 2014 and had a sticker on it saying it needed updating. The person had been admitted to hospital in April 2016 and February 2017 without an up to date hospital passport. We saw one person's health action plan contained out of date information relating to the person's nutritional support needs. The registered manager told us he would address this and most people's health plans were updated every six months.

Daily records were kept recording peoples activities, mood and the care provided. Records were also kept regarding food and fluid intake and position changes for some people, however, we found there were some gaps in records.

People told us they were able to access activities in line with their tastes and interests. One person said, "I go to my art group and I also do shop-cook-eat. I also go to the football ground." Another person told us, "I go to the Hub were we play bingo and sometimes there's a disco. I've done art this morning at the [place name]. At the home I play scrabble, but its finding someone to play with. A lot aren't able and the staff are always busy." A third person said, "I don't do any activities at all. I used to go to Day Centre but it was boring.

I like sewing and watching the television." Later they said they did 'shop-cook-eat' at college once a week. Another person said, "The Staff leave me alone when I want them to. I go into the garden and greenhouse. I love the outside. I can walk to the pub or the shops. I feel sorry for those that can't." This person told us the service had provided them with a shed to support them to complete wood-working activities.

Staff spoke with good insight into people's personal interests and we saw from people's care plans they were given some opportunities to pursue hobbies and activities of their choice. One staff member told us one person, "Likes to giggle, listen to music and watch TV. They used to have their nails done but they stopped taking [name of person] recently."

An activity coordinator worked at the service and we did not see them during the two days of the inspection as they were out with people on both days until late in the evening.

We saw from records people had taken part in activities both inside and outside the service. Some people were involved in the 'reds in the community' activity group at Barnsley football club which included some free tickets to matches. Staff told us they took people out for walks to the park and on trips out. Some people went to college to do art classes, cooking class, play snooker and do their nails and also to a weekly disco. On the second day of our inspection some people were preparing to go to a charity ball in the evening. One person went to church regularly and eight people had been to sing in the church choir the previous week. People had recently been on a trip to Cleethorpes and to a bowling competition. Staff told us holidays were planned to Euro Disney and Blackpool in the coming year.

We saw a schedule of activities on the wall which included a gardening group on Friday afternoon and Thursday was drama and music. Staff told us a person came in to the service to do arts and crafts once a week. On the second day of our inspection we saw some people doing needlepoint and chatting in one of the lounges and singing along to the radio together. We saw sensory lamps in one room and table top games around the building. However, we found one person was offered no interaction or stimulation between 11.15am and 2.20pm on the first day of our inspection except being briefly offered a drink and a meal. They became agitated and shouted for attention on several occasions, but were unable to mobilise to provide self-stimulating activities. No one spoke to or interacted with the person for over an hour, although staff spoke with other people in the room. This meant the person's needs for social and emotional stimulation may not have been met. Staff told us the person went to college once a week and on other outings a few times a week.

One person said, "If I had a complaint I would go to the manager. He's brilliant. He's always got time for me." A relative we spoke with said, "I haven't found it necessary to make any complaints."

People we spoke with told us staff were always approachable and they were able to raise any concerns. We saw there was an easy read complaints procedure on display and a 'How to complain board' with photographs of the company directors and their contact telephone numbers.

People we spoke with told us staff were always approachable and they were able to raise any concerns. We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately. For example, when a person complained about an agency staff member allegedly being rude to them the registered manager contacted the agency and passed on the complaint and asked the staff member not to return. The registered manager had also addressed a neighbour's complaint regarding car parking by improving the on-site parking facilities. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

People and one relative told us the service was well-led and people were complimentary about the registered manager. One person said, "I know who the manager is. I see him around and speak to him a lot." Another person said, "[The registered manager] is brilliant. He's always got time for me."

A relative that we spoke with said, "The manager is a lovely man. If I want to talk to him I can do. I think it is a really well run home. The staff and the manager are all brilliant and a credit to their profession."

One community professional we spoke with said, "We have always found the staff to be helpful and professional. Residents are always well looked after and staff are already found to be interacting with residents on our arrival and throughout our visit. We have not found any cause to complain or raise any issues of concern."

The registered manager had been at the home since November 2015. A deputy manager was in post and a nurse led each shift. The management team were visible in the service and nurses regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

Staff we spoke with were positive about the registered manager and told us the home was well-led. The registered manager said he operated an 'open door policy' and people were able to speak to him at any time. People we spoke with confirmed this. The registered manager told us he felt supported by the registered provider, and were able to contact a senior manager at any time for support.

We found there were some gaps in records and daily monitoring sheets which had not been addressed. Some people were at risk of pressure damage to their skin and required a special mattress with air flowing through it to reduce the risk. We found air flow mattress settings were checked regularly; however, it was not recorded in care plans what the pressure setting should be for each person. One mattress had been faulty over the weekend and required checking and the nurse on duty did not know what the correct setting should be. The registered manager told us the nurses used a person's weight to estimate this; however, the correct setting was not recorded on the check sheet or in the care plans. Following our inspection this was rectified.

On the first day of our inspection we observed one person spend all morning in the lounge with no personal care delivered between 11.15am and 2.20pm. There was no record of personal care being delivered after 9.30am when we checked the records at 6pm. The registered manager told us personal care was usually delivered after lunch and after tea and one of the nurses on duty had seen the person coming out of the lift from their bedroom in the late afternoon with staff, however, this was not recorded. The registered manager told us they would consider recording this information, but did not routinely record it. This made it difficult for managers to monitor whether care was being delivered in line with care plans. Following our inspection the registered manager sent us copies of a record which showed retrospectively that the person had received personal care at 3.30pm.

Whilst most of the time we saw people's private information was securely locked away in the office we saw the nursing office door was left open with no staff member present on several occasions. Information regarding people's 'hygiene needs' and day time activities was also openly available in the entrance hall, which could be accessed by members of the public and visitors. The registered manager told us he would address the above issues.

We saw some care files had been audited regularly in 2016 and all care file formats were changed and updated in March 2017. There were no care file audits after that time.

The registered manager told us he had introduced a weekly walk round for nurses to check the homes environment just prior to our inspection and this was due to start the following weekend. This would also involve five individual's having their room deep cleaned and personal care records checked and updated. The registered manager told us he currently checked a sample of daily records every week; however, this check was not recorded.

There were quality assurance systems in place designed to monitor the quality of care provided and drive improvements within the service. A quality assurance manager visited the service every two months to complete discussions with staff, people using the service and the manager and audit some records and we saw an action plan was completed following each visit. Some action had been taken by the registered manager in response to issues raised.

We saw some audits were completed in relation to premises and equipment. Audits of medicines, infection control and staff recruitment records were completed regularly. Daily clean checks had been audited every month. Planned individual service user weekly file audits had been completed a maximum of twice a month, with none in April and May 2017, one in June and none in July 2017.

External medicines audits had been completed by the pharmacy the service used in March 2017 and by the local authority in May 2017. An issue raised by a local authority audit regarding nurses signing medicines administration records prior to administration was also found during this inspection. This showed staff compliance with some of the service's procedures was monitored; however, the system was not always effective in identifying and addressing the problems we found.

As discussed previously in this report, we found sufficient action had not been taken since our last inspection regarding staff training to ensure staff had the skills and knowledge to deliver effective care.

Information was passed to the registered provider by the registered manager every month regarding incidents, complaints, supervision, and health and safety. The registered provider had completed written supervision with the registered manager since April 2017, although evidence prior to this was not available. The registered manager said he felt supported by the directors who visited the service regularly to provide support.

This demonstrated the senior management of the organisation were reviewing information to try and drive up quality in the organisation, however, the systems in place had not identified and addressed the problems we found.

The above issues evidence a breach of Regulation 17 (2) (a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had addressed some of the issues raised on the first day of this inspection by the

second day, and following our inspection sent evidence of the action they had taken and plans in place to further improve the service.

Staff told us senior managers visited the service regularly. One staff member said, "[Name of director] is a lovely bloke. He came last week. It is a good company."

We found Incident reports had been reviewed by the registered manager in a timely manner and an analysis of incidents had been completed to look for trends and patterns with a view to preventing future incidents. This demonstrated the registered manager had oversight of the safety of the service.

People who used the service, their representatives and staff were asked for their views about the service and these were acted upon. Residents' meetings had been held in August and October 2016 but not since. It was not clear why further meetings had not been held. We saw the home had sent out a satisfaction survey to people who used the service and family members in November 2016 and the feedback was largely positive. Any issues raised had been analysed and addressed by managers. This meant people's views were taken into account and they were encouraged to provide feedback on the service provided. The registered provider also facilitated a fundraising group which included people using the service, and a charity ball had been organised to raise funds for chosen charities.

A staff survey was also completed and a suggestion box was available for staff to comment. Staff meetings were held every month. Topics discussed included safeguarding, record keeping, care plans, confidentiality, audits and incident management. Meetings had also been held with senior staff. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

The registered manager told us he attended training and good practice events and was supported to keep up to date with his professional registration. He was signed up to good practice updates through professional networks and attended training and meetings with other managers. This meant the registered manager was open to new ideas to improve practice at the service.

The registered manager understood his responsibilities with respect to the submission of statutory notifications to the Care Quality Commission (CQC). Notifications for all incidents which required submission to CQC had been made.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental capacity was not always considered when decisions needed to be made. 11(1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate records were not always kept. Effective quality assurance systems were not in place to improve the quality and safety of the service. 17 (2) (a) and (c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always received sufficient training to enable them to provide effective support to people. 18 (2) (a)

The enforcement action we took:

Issues warning notice to comply within 28 days