Regal Healthcare Homes (Coventry) Limited

Haven Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 8 and 10 September 2015, and was in response to concerns raised by staff and relatives about the quality of care provided. The inspection was unannounced.

Haven Nursing Home is a large nursing home which provides nursing care for a maximum of 70 people in three units. People whose primary care need is dementia, are mainly supported in Birch Unit. Older people and people with more complex nursing needs are mainly supported in Oak and Elm units. At the time of our visit there were 64 people living in the home.

The service did not have 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. The registered manager left the service at the end of May 2015. Since then, two other managers had been appointed and left. The last one had worked for the provider for five weeks and left suddenly. We were concerned about the high turn-over of managers at the service, and the lack of leadership from the provider in

Summary of findings

relation to the monitoring of the quality of service provided. The provider had arranged for an interim manager from a consultancy agency to work at the home to provide management cover.

The provider of the service has a history of non-compliance with regulations and any improvements made in relation to the quality and safety of service people receive have not been sustained.

Staff were not always available at the times people needed them, and gaps in the planned staff rota were being filled with agency staff. The use of agency staff to cover staff vacancies meant people were not provided with continuity of care by staff who knew them well. There was no clear process used by the provider to determine the number of staff required. The provider did not provide sufficient staff to meet the needs of people, or take account of the size and layout of the building.

Staff were kind and tried their best to provide care. However, staff interaction with people was when supporting them with care tasks. We saw little involvement between staff and people at any other time of the day. There were limited opportunities for people to be involved in social activities, particularly for people living with dementia and who had been identified as having behaviours which challenged.

People who were independent received food and fluids which met their nutritional and hydration needs. We were concerned that people who received a pureed diet did not have the choice that other people had.

The personal care provided did not always meet people's preferences or expectations. Most people only received a shower once a week and records showed that many were not supported to have a wash at night or their teeth cleaned. Care provided was task orientated and not tailored to the needs of each individual (person centred care).

People did not feel their concerns were listened to. We could not see an accessible policy to inform people how to complain about the care provided. The records of complaints investigations did not provide the outcome of the investigations.

Since our last visit, staff at the service had applied to the local authority for some people who required a Deprivation of Liberty Safeguard in order to ensure people's liberty was being lawfully restricted. However, we could not be certain that applications had been submitted for everyone who had restrictions on their liberty. We were concerned that people had been restrained through the use of 'as required' medication and bedrails were used without consideration of whether this was in people's best interest or the least restrictive option.

Relatives and friends were able to visit the home at any time of the day.

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

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.

Summary of findings

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe

There were not enough staff available to meet the complex needs of people who lived at the home. People were not provided with continuity of care because staff had left, and vacancies were being filled by agency staff who did not know people's needs.

Risks were not always appropriately managed, and medicines were not always managed safely.

Inadequate

Is the service effective?
The service was not consistently effective.

Staff had received training considered essential to meet health and social care needs. However, people with dementia did not always get the support they required. This was because staff had not received specialised training. The Mental Capacity Act was not always adhered to and this meant people's best interests were not always supported. People received the health care support they required from external health and social care professionals.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff were kind, and wanted to provide good care to people. The number and deployment of staff meant care was task focused and not focused on the individual.

Requires improvement

Is the service responsive?
The service was not responsive.

People were given limited opportunities to follow interests or be involved in social activities. Personal care was not responsive to people's individual likes and dislikes. People did not know how to raise concerns and thorough complaint investigations had not been undertaken.

Inadequate

Is the service well-led?
The service was not well-led.

Since our last inspection in March 2015, the provider has had three different managers in post at the home, all of whom had left their employment within a short space of time. At the time of our visit there was no manager. Many staff and some of the relatives we spoke with felt the provider did not understand the issues regarding the home and the improvements required. The provider did not have adequate checks and systems to support the leadership and management of the home.

Inadequate

Haven Nursing Home

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 8 and 10 September, and was unannounced. The inspection team consisted of three inspectors. We visited the home because of concerns raised by members of the public and staff about the quality of care provided to people who lived at Haven Nursing Home. Prior to our inspection we also reviewed safeguarding information, and notifications sent to us by the service.

During our inspection we spoke with six people who used the service, and 15 relatives and friends. We spoke with 12 staff (this included domestic, care and nursing staff, administration and activity workers) and the provider.

We used the Short Observational Framework for Inspection (SOFI) in two areas of the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent significant time observing the care provided to people in the home throughout our visit.

Prior to our visit we received information about the home from the local authority contracts monitoring team, and the Clinical Commissioning Group (CCG). After our visit we contacted the speech and language team, and the dietician for the home. All had concerns about the care provided to people.

We looked at six care records, a minimum of five supplementary records (for personal care, food and fluid intake) in all three units, the medicine administration records, staff rotas, and complaints.

Inadequate

Is the service safe?

Our findings

Prior to our visit we received concerns from staff and relatives about the number of staff available to provide safe care to people who lived at Haven Nursing Home.

We asked people whether there were enough staff to support their needs. One person said, "The girls are run off their feet, there are not enough girls." Another told us, "Getting to the toilet is difficult, as it takes two people. Finding two people to take me to the toilet at the same time is nigh on impossible. I have to wait." They told us it became very uncomfortable when they had to wait.

We asked visiting relatives whether there were sufficient staff to support people. One visitor told us, "It doesn't look like it to me. It often feels as though they could do with more support. You often feel there is not much flexibility." They went on to say, "We didn't like it the other weekend (Bank holiday weekend) because they took everybody into the main lounge so they could oversee it better." Another relative told us, "There is not enough of them and they are overworked." We asked what the impact on their relative was and they told us, "Sometimes we come and she needs changing so we have to call them."

Most staff we spoke with told us there were not enough staff to provide anything other than basic care and nursing needs. They told us that as a consequence of staff leaving, annual leave and sickness, the provider had to use agency staff. This meant there was a lack of continuity of care because agency staff did not know the people they were supporting well, and the service could not always arrange for agency staff to cover the gaps in the staff rota. Nursing staff told us, "We are firefighting, we should have one nurse for each unit; sometimes there are only two nurses for the three units. We never have time for care plans because nurses who were in charge have left." Another nurse told us, "Every resident needs to be assisted by two people to have personal care, to feed them, to reposition them. This is hard when 25 residents are dependent on two carers, especially on Oak Unit. They explained to us there should be six care workers on Oak and Elm, and three on Birch but "Even with six, six and three it is still a struggle". They went on to say,"The carers are exhausted, they don't finish personal care because then they start lunch." We asked a member of nursing staff if they felt people were safe. They told us, "No, I don't think people are safe. I think we have avoided things happening through some of the carers being very good, but I am quite certain there could easily be something happen."

We saw people were not given the support they needed. For example, we undertook a SOFI from 11.50am to 12.40pm in Oak lounge (a lounge/dining room). For most of the time, there was one member of staff in the lounge to meet the needs of 15 people who were sitting there. One person was already waiting for their lunch at one of the dining room tables at 11.50am. They did not receive their meal until 12.35pm. During this time a person sitting in an armchair kicked out and knocked over a side table twice. The table almost knocked people who were sitting at the dining room table. Another person cried out 'help' on several occasions. A passing member of staff heard this and came over to the person to give them some comfort. As they were in the middle of taking a hoist to another person in a different area they could not stay and continue to give support.

People were cared for in bed because there were not enough staff to support them with personal care and to assist them out of bed. A relative told us, [Person] has been in bed for three days. [Person] should be up every day at 11.30am, there have not been enough staff about." One care worker we spoke with mid-afternoon told us four people in bed had not had any personal care that day. They also raised a concern that some people were staying in bed all day for "no good reason." They said about one person, "The whole week they have been left in bed. There is no staff and by the time they get to them at 3.20pm there is no point getting them out of bed." We saw another person had been left in bed on both days we visited. Records identified the person could become agitated when they got out of bed, however they appeared to be kept in bed because there were not enough staff to support them. We concluded this because one care worker told us the person was excluded a lot because of their behaviour. We saw in the person's daily care notes they were nursed in bed for four days between 1 September and 9 September. There was no reason recorded as to why they were kept in bed.

We asked the provider if they had a system to determine how many staff were needed to provide safe support to people. They showed us a 'staff to resident' dependency tool they had asked the manager to use. We looked in people's care files and saw people had been identified as

being low, medium or high dependency but it was unclear how their dependency had been assessed, and there was no evidence to indicate that this information had been used to determine staffing levels. The administrator told us staffing was linked to the number of people who lived in the home and not dependency levels.

We looked at the number of staff on shift throughout the day and night. We saw that on both Elm and Oak units, the number of staff decreased in the afternoon by one. There was no rationale for why the number of staff was reduced. The impact this had on people who lived at the home was further compounded by staff going on their half hour lunch breaks after people had finished their lunchtime meals. A care worker told us that on Birch unit, this meant for 1.5 hours there were only two members of staff to support up to 13 people with complex dementia care and personal care needs. There were eight people on the unit at the time of our visit.

Staff levels further reduced at 7pm to two nurses and six care workers for the 64 people who lived at Haven at the time of our visit. We were concerned, there were insufficient staff during the early evening to support people's complex needs, provide personal care and support people to go to bed at the time they wanted. One person told us, "There are definitely not enough (staff) at night…You can tell there aren't enough as the call bells keep ringing." This person added "I sometimes have to wait longer for paracetamol than I would like when I need it."

Some people required staff to support them to reposition their body to reduce the risks of skin breakdown and pressure sores. One member of staff told us, "Re-positioning is not happening as often as it should." We looked at a repositioning chart for one person who was to be repositioned every 2-3 hours. We saw that over the previous two days they were being repositioned mostly as required in the morning and early afternoon, but on both days there was a gap of seven hours from 4pm to 11pm when there were less staff available. This meant that due to staffing levels people were more at risk of their skin breaking down and developing pressure sores.

At our last inspection in March 2015, we heard call bells being responded to quickly. There were also signs on the doors informing staff of people who could not use call bells and to remind staff to check their well- being. This was not the case on this occasion. We heard the call bells sounding very frequently when we were at the home, and there were no prompts to inform staff to check people who could not use them.

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

We asked one person if they felt safe at the home, and they said, "No, not at all." They told us there were not enough staff to, "Keep an eye on people, and sometimes things start and there is no one to protect you."

Staff we spoke with understood the principles of safeguarding adults from abuse and were aware of the need to report any concerns immediately to senior staff. Some were unsure who they would report to given the absence of a manager, but stated they would speak to one of the senior nurses. Whilst staff understood their roles to report issues, when we looked through the incident and accident book we found incidents had occurred which had not been reported to the safeguarding authorities. In August there had been three incidents where one person had hurt another; and one incident where a person had their legs stuck in the bed rails. None of these had been reported to the local authority safeguarding team or to us at the CQC. We also saw two incidents where people who lived at the home had been physically aggressive, and injured staff, but there was nothing to indicate any changes had been made to either protect the person or the member of staff.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment.

Risks associated with people's care were not always managed appropriately. The provider had risk assessment record sheets, but these were not always completed at the service and the record did not always inform staff of what they needed to do to minimise risk. For example, one person was at very high risk of skin damage because they were not mobile. Their risk management care record stated, 'pressure relieving equipment available' but did not specify what equipment was needed to minimize the risk. Another person, when agitated, would sometimes put themselves on the floor. The care record informed staff to use a hoist when this happened. However the record did not inform staff of the size of sling the person required to use with the hoist. We asked staff if they knew this. One

member of staff told us they would use, "The largest one we have got"; whereas another member of staff said they would use a medium sized sling. This meant the person was at risk of being hurt if they were moved with the wrong size of sling.

We saw three people who had dressings on their legs. One had a dressing which was not the right one according to their care record. We were told this was because the correct dressing was not in stock. Records showed that two others had their dressings last changed and evaluated on the 25 August and 22 August respectively. Staff were unable to confirm whether these wounds had been dressed or evaluated for over two weeks, and this meant there was a risk of the wound become dirty and infected.

There were people who lived at Haven Nursing Home who used urinary catheters. These needed to be changed regularly. There was no central record to remind nursing staff when catheters should be changed. This meant nursing staff (and agency nursing staff) might not change the catheter at the required time which could result in a blockage or an infection. There was only one nurse employed by the service who was competent to carry out male catheterisation. If this nurse was not on duty when a catheter required changing because of blockage, pain or infection, staff would have to call the on-call GP or district nurse. This might delay the change and add to the risks and discomfort of the person.

We checked the safety of the administration of medicines. We observed a nurse administering medicines to people. When they gave a person their medicines, they left the medicine trolley with the keys in and medicines were left on top of the trolley. This meant there was a risk of people taking medicines which were not prescribed to them. The nurse was interrupted on a number of occasions because people became agitated, and because they had to assist someone with their breakfast. The nurse told us it was normal to be interrupted and 'very frustrating', adding that "It is not a safe and effective way to practice."

We looked at medication administration sheets (MARS). Some people had not received their medicines because they were out of stock. We could not find out why these were out of stock or what impact this had on the people who did not receive them. This was because of the lack of continuity of nurses administering the medicines.

During our last inspection we saw handwritten medicine records had not been countersigned by another member of staff to confirm the medicine regime had been hand written accurately. We saw poor practice in relation to this had continued.

We asked to look at the provider's medication policy. We were told the previous manager had been working on this. We saw the medication policy was the Nursing and Midwifery Council Standards for Medicine management, not a policy and procedures for staff.

We looked at medicines given to people on an 'as required' (PRN) basis. At our last inspection we had concerns that there was insufficient information for staff, to ensure people given 'as required medicines' were given them consistently and safely and without impacting on their human rights. At this visit, we saw again that a number of people were prescribed medicines which were to be given to reduce anxiety and when people displayed challenging behaviour. There continued to be limited information to inform staff of strategies which should be used to de-escalate anxiety or challenging behaviour before people were calmed by prescribed medicines. This meant there was a risk medicines might be administered before all other interventions had been explored, with people being chemically 'restrained'.

This was a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of people who lived at Haven nursing home who had medicines given 'in disguise (covert). A letter from the person's GP confirmed the decision to give medicines covertly had been made in the best interest of the person by a multidisciplinary team. A member of staff told us this team included a consultant pharmacist based at the GP's practice.

Requires improvement

Is the service effective?

Our findings

At our last inspection in March 2015 we found staff had restrained some people by holding down their arms when they exhibited behaviours which challenged; this meant the provider was in breach of Regulation 11 (Need for consent) of the health and social care act 2008 (2010 regulations). There was nothing in their care records which told us this was the least restrictive option and made in the person's best interest.

At this inspection we found a staff member had undertaken training to be a trainer to staff in the home on techniques to diffuse and de-escalate behaviours which challenge, to reduce the necessity to restrain people. The member of staff told us they had planned to deliver this training to staff at the end of September 2015, but it had been cancelled because there were not enough staff to support people's needs in the home.

We were concerned staff were using bedrails as a form of restraint to keep people in their beds because their behaviour was challenging. In Birch unit, which supported people with dementia, there were two people who were very distressed. We saw staff struggle to support their needs, as well as the needs of the other people on the unit. Later in the day, we saw one person had continued to be distressed and were heard crying out behind their bedroom door which was shut. We went into their room to find them in bed with the bedrails up. We asked a member of staff who knew the person well why the bedrails were up. They told us they were probably up to stop the person from getting out of bed, and this happened a lot when staffing was short. The member of staff knew it was a form of restraint and was unhappy with the practice but indicated it was the safest option when staff numbers were low.

We checked to see if the service was following the guidance set out in the Mental Capacity Act (MCA), in respect of the person we saw restrained in bed. The MCA covers situations where someone is unable to make a decision because the way their mind or brain is affected. The person's care record had a risk assessment in relation to the use of bed rails which was not very clear, and the assessment said the next of kin had given consent for bedrails to be used. However there was nothing to indicate that a best interest decision had been taken to demonstrate this was the least restrictive and safest option for the person, and when the bedrails should be used.

We looked at some of the assessments the service had conducted on people they considered lacked capacity. The assessments did not always clearly inform in which circumstances the person lacked capacity. For example, one person's capacity assessment read, "Has understanding to contribute to all activities of daily living, pressure care, washing and dressing, nutritional needs, elimination and toileting and the administration of medication." This was dated February 2013 but this person had been assessed as not having capacity to understand the implications of refusing medicines and was being administered medicines covertly (disguised in their food).

This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care act 2008.

People who lived at Haven Nursing Home did not always have their assessed needs, preferences and choices met by staff with the right skills and knowledge. This was because, whilst staff had been supported to undertake training considered essential to meet people's health and safety, such as moving people, infection control and safeguarding; they had received limited training in specific areas such as dementia care and behaviours which challenge.

The provider had said of their service, on a website advertising their home, that, 'Staff are highly-trained in quality methods, including for individuals with dementia, taking a person-centred approach to all care issues while supporting individual choice and lifestyle alongside well-being.'

The dementia care training was a two to three hour training course and provided a basic understanding of dementia. It did not provide the skills staff needed to support the people at Haven Nursing Home living with dementia. Whilst Birch was identified as the dementia care unit, many people in Oak and Elm units also lived with dementia, with varying levels of impact on their lives. Staff told us there was no planning to determine which staff had the right skills and knowledge to work in which area of the home. Staff told us that some staff did not like working in Birch because they were "afraid" of the people and did not feel equipped to support them. When asked if the home offered good dementia care, one staff member told us, "To be honest with you I do not know what you mean by good dementia care."

We spent time observing staff work with people on the dementia unit. We saw that not all of the staff had a good

Is the service effective?

understanding of how to work with people living with dementia. We asked one member of staff some questions about dementia care. They told us they did not understand how to support people and had a lot to learn.

This was a breach of Regulation 18 (Staffing) (2a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our visit, we had received a concern from a person about the quality of food provided. They told us they were happy with the meals provided to their relative when the cook was working, but not with the meals provided by a care worker who had taken on the role of cook, whilst the cook was on annual leave. They had heard the care worker was going to continue in this role despite not having the qualifications to do so. We checked this with the office staff. They informed us that the person was going to continue in their role as a care worker until they had undertaken the appropriate training to work in the kitchen.

We spoke with a health care professional from the community speech and language team. They told us they had concerns about the lack of choice for people on pureed diets. They told us they had recently visited the service and found that people on a pureed diet had no choice of meal at lunchtime, and received soup in the evening. They were told the soup was thickened for people with swallowing difficulties by 'blitzing' bread with the soup. There was no choice if people did not want soup. They were also concerned at the lack of knowledge staff had in relation to people with dementia, as one member of staff had referred to a person as 'lazy', in response to their eating. They told us that this person had dementia which is often characterised by a poor appetite and a need for staff encouragement to support them to eat.

We saw people who did not have pureed diets, enjoyed their meals and there were choices available. One person told us, "The food is very, very, good, I've no complaints about the food." One relative told us, "The food is of good quality and the food is always pureed individually."

Whilst people enjoyed their meals, the dining experience for people was mixed. Those who needed support to eat did not always receive consistent support. Whilst observing lunch in one of the lounges, one staff member was assisting a person with their lunch but was called away to attend to another person as there was no other member of staff available to do so. The person eating was then assisted by a different staff member after a gap of approximately five minutes. In Birch lounge where people living with dementia were eating their meals, staff asked people what choice of meal they wanted. Some people did not understand what was being said. Staff did not show the meals to help them see the choices, but kept repeating the information that the choice was chicken casserole or potato pie.

Staff did not always know what people needed or wanted to eat or drink. Prior to our visit we received concerns from a relative that their relation who lived with dementia, was diabetic and was asking for, and getting sugar in their tea. They told us the staff member on duty did not know they were diabetic.

We did not see any health care professionals on the days of our inspection; however care records showed that people had seen their GP when requested and other healthcare professionals such as the optician and chiropodist. On the first day of our inspection, a person was being escorted to hospital by a member of staff so the person could attend an out-patients appointment.

Requires improvement

Is the service caring?

Our findings

We asked people and their relatives whether they felt staff were caring. People told us staff were mostly caring. One person said, "The staff are very good to those who are very good to them…I feel sorry for the staff, they work hard." Another person said, "Most staff are kind."

One relative told us "In general the girls here are very caring and do everything they can but there are limitations on what they can do with the time and staff they have got. I feel for the staff because 90 per cent of them are doing a good job and would like to be doing a better job with support." Another relative told us, "They don't have time to nurse and do the caring work."

The service has three units, Oak, Elm and Birch (dementia and behaviours which challenge). We spent time in each unit's communal lounge observing staff interaction with people. We saw staff trying their best to provide supportive care, but the lack of staff meant staff only had the opportunity to show kindness and care when they undertook a task, intervened in a situation or tried to move people from one place to another.

Staff wanted to provide a caring service. They told us they knew what they were providing to people was not as good as they would like, however they felt exhausted. One member of staff told us, "We've had care assistants in tears because they have had so much to do." Another said, "We are constantly in crisis we provide basic level needs, we are not doing any of the 'add-ons', I feel really sad about it." Staff told us that those staff who had left the home had left with "A heavy heart" because they had loved working with people but didn't feel they had been given the care and support by the organisation.

People were restricted in movement and in what they wanted to do. For example, In Elm unit we saw a person with a frame get up and start to walk. Another person in the lounge saw this happen and called out to staff to let them know (the care worker was busy and could not see the person had started to move). We then saw the staff member discourage the person from walking and sat them back in their seat. When we asked why, we were told the person was a risk of falls. We asked if they would fall if a member of staff went with them, and were told they wouldn't but there were not enough staff to do this. This meant people were not being able to be as independent as they wanted to be.

Staff were not employed to work in a specific unit. We were told this was to provide more flexibility when covering staff absences. However, for people living with dementia this could be more confusing as they did not have a regular and consistent staff group. They also had staff who were not at ease because they had not received the appropriate training to work with people who lived with dementia or who had behaviours which challenged. Staff did not always know the people they were caring for and supporting. This was because staff did not have the opportunity to look at care plans; and because some of them were agency staff were not familiar with the people who lived at Haven Nursing Home. A relative told us, "The agency nurses don't know anybody."

There were no restrictions in visiting times for friends and relatives of people at Haven Nursing Home. We saw visitors stay for long periods of time during the day to support their relations and provide company for them.

Inadequate

Is the service responsive?

Our findings

We looked to see if people were provided with personal care the way they would like to receive it. We looked at the hygiene records and saw people usually received a wash and mouth care in the morning, however records did not show people received personal hygiene or mouth care in the afternoon and evening. A person told us they received personal care every morning but went on to say, "Personal care in the evening doesn't happen. I don't get a wash or my teeth cleaned." They said they didn't mind not having a wash, but would have liked to have their teeth cleaned, but, "Not if it delayed going to bed." They continued to say, "I don't always go to bed when I want to."

One relative told us staff did not respond to their relation's hygiene needs. They said, "Quite a few times we have to ask them to bath [person]. Sometimes they have gone three weeks without a bath, shower or hair wash." We looked at the person's care records. They had waited 16 days between their previous and most recent shower and hair wash. We found personal care in the evening was very limited and people were not receiving personal care in the morning at the time they wanted it. A member of staff told us, "Before 11.30am we would be finished (with personal care), but now we are taking so long and families are complaining. It's not fair to see them like this, it is a lot of money they pay, we are not happy."

Whilst we observed care provided in the Birch Unit we saw a care worker brush the hair of three people with the same brush, then put it back into the drawer. They did not check with each person whether they wanted their hair brushed but went from one to another in quick succession. This did not provide personalised care to people, and did not respect people as individuals.

At our inspection in March 2015 we had identified this as an area which required improvement. The provider has not taken any measures to improve this.

At our last inspection in March 2015, the provider had employed an activity worker to work at the home for 20 hours a week. Since then another activity worker has been employed to provide additional activities in the home. This meant there was 40 hours a week of activity support provided. During this inspection we saw the activity worker undertake some activities with a small group of people. We were told the service tried to involve relatives and families with activities as well as people who lived at Haven. A relative confirmed they had been involved in activities and often joined in when visiting. However, we found that 40 hours of activity support a week was not sufficient to fully engage all 64 people who lived in the home. One person said, "I don't do much in the day, it's a bit boring at times." They also told us that the larger lounge in the Oak unit was used if a concert took place in the home. They said they would often choose not to go to the concert because they had to wait so long for staff to take them to the lounge, and wait a long time to be taken back.

There was a timetable of activities visible in the home. However, it was in an area where not many people passed, so the majority would not be able to see what activities were available. We were told activities such as pet therapy, aromatherapy, music therapy and games were on offer at the home, although we did not know how often these activities took place, and how much involvement people had in deciding what activities they wanted. During the two days we were at Haven, we saw very little which stimulated people in either Oak or Elm, and nothing to support the interests of people in Birch. In Oak and Elm, whilst there was some engagement with the activity worker, people spent most of their time sitting in front of a TV showing programmes they showed little interest in and were mostly, not watching. For example, in Elm, the TV was showing a reality programme of an American court. We did not see staff use music or any other types of stimulation to engage people. One person had a birthday during our inspection. We saw a banner and balloons had been placed next to where they sat, and a birthday cake had been made with their name written on the cake. However, during the time we were there we saw little engagement with the person, or any other person sitting in the same lounge.

In the Birch unit which is a dementia care unit, we saw very little activity which supported people with their dementia care needs. Staff did not have time to engage meaningfully with people, and we were told the activity workers rarely undertook activities with people living in the unit. This was confirmed when we looked at the activity records of a person who lived on Birch. Their activity records showed two activities had occurred in the last four months. One was recorded as a chat about the weather, and the other was that the person's room had been decorated for their birthday.

Inadequate

Is the service responsive?

At our last visit, Birch unit had two lounges. One was a smaller designated quiet lounge. We saw this lounge had been changed to be a bedroom. The lounge/dining room people used was not very spacious, and gave people limited opportunity to move around. This meant when people were feeling agitated or anxious they had to go back to their bedrooms. A staff member told us it felt like the person was being punished by being sent to their room.

We saw very few resources available to people. We saw some soft toys that people enjoyed holding and caring for. We were told these had been brought in by relatives and were not part of planned expenditure on dementia care resources. We did not see any resources which would provide good dementia care, such as reminiscence books, art activities, or activities which would give people a sense of purpose. A relative of a person who lived in Birch told us, "[Person] doesn't do very much; [person] isn't interested in the TV and doesn't read." A staff member told us, "I don't think we are stimulating them as much as we could or should be." Another said, "They just sit there don't they and walk around." We asked about activities and they replied, "I don't think it ever happens." We asked a member of staff if the home provided good dementia care. They responded, "It is like they have been put in jail. They have no life. They don't have much freedom and I have never seen activities co-ordinator take them out even if it is a nice day."

We looked at people's care plans. We found these had not been reviewed for two months. A nurse confirmed that nurses had not had the time to update people's care plans and was concerned this put people at risk of not receiving the care and support they needed.

The care plans for people were kept centrally in the nurse's office. This meant they were not easily accessible to staff who had to leave their individual units to read them. We asked some staff if they had time to read care plans. They responded, "I don't know anything about care plans." Another said, It has been a little while since I read them, I haven't had chance to."

We spoke with a relative of a person who had recently moved in to the home. They told us a member of staff came to the hospital to assess their relation, however whilst they asked about food, they did not ask them about their preferences, or anything about the person's history. This meant staff would not know how to provide personalised care to the person.

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

We looked at whether the service had received any formal complaints since our last inspection. We found there had been a few since our inspection in March 2015, and there had been some investigation to address them. However, we could not see any letter to the complainant informing of action taken to address the complaint and the timescale by which they would be informed of the outcome of the investigation.

We could not see an accessible complaints policy or procedure, which informed people of how to make a formal complaint. Some relatives told us they had spoken with the manager and the provider about concerns in relation to care and felt they had not been listened to. One relative told us they had spoken with the provider about staffing and they had replied, "But we have five here and five there." Another told us they went to see the provider when they were visiting the home about concerns and felt they were 'fobbed off' and not listened to.

A relative told us they had gone to the most recent manager to share their concerns about the staffing levels and said, "The door was kept shut. I knocked on the door and a voice said can you come back, I am busy." They told us when they finally spoke with the manager they "Got a sob story about her problems."

This was a breach of Regulation 16 (Receiving and acting on complaints) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Since registering with the Care Quality Commission the provider of this service has a history of non-compliance with the regulations. In December 2012 the service was inspected under the previous methodology and found non-compliant in three of the four areas inspected. This included non-compliance in care and welfare, meeting nutritional needs, and management of medicines. In February 2013, a follow up inspection found them to be compliant in the previously non-compliant areas. In October 2013 an inspection found the service to be non-compliant in Care and welfare, staffing, and assessing and monitoring the quality of service provision. In March 2014 an inspection found the service compliant again. On 18 March 2015, the service was found to Require Improvement overall, and 'required improvement 'in every area except 'caring' where it was judged as 'good'.

We visited the home because we had received information that the manager for the service had left on Friday 4 September 2015 without giving notice, and there was no managerial oversight of the service. We were concerned because this had been the third manager since our inspection in March 2015 who had left the service, and the fifth in the last year. We were also informed that the deputy manager had left.

The provider had contacted a management consultant agency and arranged for a person to provide management cover until a new manager was appointed. This person was known to the home as they had previously supported the service to improve when it had been non-compliant in the past. This person started to provide cover a few days after the previous manager had left. Staff told us the provider did not attend the service at the week-end to provide any reassurance to staff about what steps they had taken to provide managerial support and that they were disappointed this had not happened.

On the first day of our visit we met with a person who was previously the nominated individual for the service (the person who is legally responsible for the provision of the service). They told us they had not been involved with the service since April 2015, and they had submitted information to the CQC in July 2015 to change their legal status. We confirmed this had happened. They told us they had attended the service because the provider had asked them to ensure there was management cover.

We met the provider on the second day of our inspection. We discussed their actions in relation to the recruitment and support given to managers, and discussed the differing reasons for managers leaving. As a consequence of our meeting we judged the provider did not have an effective and safe management recruitment process; they did not had sufficient structures in place to support the managers they had appointed; and did not have a clear understanding of what was happening in their home. They put the responsibility for the failures of the home on the management they had recruited, and did not look at what they needed to do to give management the support they needed.

The provider told us they were not an expert in providing care, and they expected their manager to provide the expertise. They did not have any quality assurance systems or use external advisors to provide assurance that they were meeting their regulatory requirements. However, they had recruited managers who had no experience of residential care, and who had not been given the required support to help them understand their responsibilities under the Health and Social Care Act 2008.

As well as meeting with us on the day of inspection, the provider, despite having told us that they were not experts in care, interviewed for a new care manager and provisionally offered the person the post. This meant that whilst the person offered the position, may have the skills and experience expected, they did not go through a robust recruitment process which assured they were the right person to manage the home.

Relatives and staff voiced their concerns about the leadership of the service provided at the home. A staff member told us, "It has been very difficult with all the different managers and nothing seems to have been got in place. We have lost some really good managers. They have all come in with good ideas but they are restricted by the owner." Another member of staff said, "I think they [manager] have been under a lot of restrictions from the owner. Keeping costs down. They [managers] want to bring things in, they put it to the owner and it is down to what he says really." A relative told us about the provider, "I believe they live in [southern county] so they are not exactly hands on. I don't know how easy it is for people to get in touch with him."

Staff told us that the lack of quality assurance systems and inconsistent leadership had contributed to staff being

Inadequate

Is the service well-led?

demoralised and leaving. Systems were not in place to ensure that medicines were managed safely, care records were not being updated and effectively used and people did not receive personalised care that met their needs and preferences. Notifications were not being sent to the authorities when they should and people were being inappropriately restrained. People with complex nursing and dementia care needs were not receiving the care they needed to keep them safe and well.

This was a breach of Regulation 17 (1) (2a) (2b) (2c) (good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care was task focused, not focused on the needs of each person. This meant individual needs had either not been identified or acted on. People's social care needs were not met because staff did not have the time to provide interests or activities for all. People in the dementia unit experienced very little engagement to meet their social care needs.

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 How the regulation was not met: Staff did not act in accordance with the requirements of the Mental Capacity Act 2005 to ensure that decisions to restrain people were in their best interest.

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 How the regulation was not met: The provider did not ensure the proper and safe use of medicines, or ensure there was always sufficient stock, to meet people's needs. The provider did not ensure risks were recorded and responded to appropriately.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not met: There was not an effective and accessible system for identifying, receiving, recording, handling and responding to complaints.
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 How the regulation was not being met: (1) People were not receiving the personal care they required to be safe, because there were insufficient staff to meet their needs. (2a) Staff had had not received appropriate training to enable them to support people living with dementia.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have effective systems and process to make sure they assessed and monitored their service to ensure compliance with the requirements of the health and Social Care Act 2008. The provider did not have regular audits of the service which could monitor and improve the quality and safety. There were not process which included finding out the experiences of people who used the service. The provider did not adequately monitor the risks relating to people's health. The provider did not have accurate records of all decisions taken in relation the care and treatment of people.

The enforcement action we took:
We have issued the provider a 'Warning Notice' under Section 29A of the Health and Social Care Act 2008. This means the CQC has formed the view that the quality of health care provided by Regal Healthcare Homes (Coventry) Ltd for the regulated activities above, requires significant improvement.