Craighaven Limited

Craighaven Care Home

Inspection report

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Warwickshire
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Tel: 01926429209

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 14 June 2017. The inspection was unannounced.

Craighaven Care Home is registered to provide accommodation and personal care for up to 35 older people who are living with dementia. On the day of our inspection visit 32 people lived at the home.

There was a registered manager in post. 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.

At our last inspection in April 2015, the service was meeting the regulations and we had rated the home as 'Good' overall. During this visit we found previous standards had not been maintained and the homes rating was now 'Requires Improvement' overall.

A combination of staff deployment and/or insufficient staff meant staff were not always available to respond to people's requests for assistance and to support people's social and emotional needs.

The provider's medicine systems and checks did not ensure medicines were consistently administered safely and by trained staff. People saw health professionals when needed.

Staff had not been supported to complete essential refresher training to ensure they continued to have the knowledge and skills to carry out their roles effectively. Staff had been recruited safely and received an induction when they started working at the home. However, the induction for new staff did not follow the expected Care Certificate standards.

The provider had not maintained effective procedures to check and monitor the quality and safety of the service people received. This meant the provider was not aware of potential poor practice and areas where improvement was necessary.

People's care records were not always detailed and contained conflicting information. This meant they did not provide staff with accurate and consistent information about how people should be cared for and supported. However, staff spoken with had a good understanding of the needs and preferences of the people they supported.

People were not always offered a choice of meal in a way they could understand and some people did not always receive the necessary support they needed at meal times. People had opportunities to take part in in individual or group activities and were encouraged to maintain links with friends and family who could visit the home at any time.

People and relatives told us staff were caring, kind and patent. People received care and support from staff they knew and who respected their privacy. Where possible, staff encouraged people to be independent and involved them and their relatives in planning their care.

People and relatives told us they felt safe using the service. Staff understood how to protect people from abuse and most understood their responsibility to report any concerns. Risks associated with people's care and support had been assessed. Premises were well maintained and equipment was checked to ensure it was safe for people to use.

The registered manager and staff had an understanding of the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DoLS) for people whose freedoms were restricted. However, some best interests' decisions had not been assessed and people's consent had not always been sought in line with the requirements of the legislation.

Relatives felt the registered manager was approachable and the home was well managed. Complaints were managed in line with the provider's policy. Staff felt supported and valued by the management team who were accessible and responsive.

We found two breaches of the Health and Social Care Act 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 is not always safe.

Staff were not always available to support people when needed. Medicines were not consistently managed and administered safely. Staff had been recruited safely and relatives told us their family members felt safe with staff. Staff had access to information about risk related to people's care and how these should be managed. Premises and equipment were well maintained and safe to use. Staff knew how to safeguard people from harm and most understood their responsibility to report any concerns.

Is the service effective?

Requires Improvement

The service is not always effective.

Staff had been inducted into the organisation yet the induction for new staff and existing staff did not reflect the expected Care Certificate standards. On-going training for staff, to ensure they had the knowledge and skills to deliver safe and effective care to people, had not been maintained. The provider had an understanding of their responsibilities under the Mental Capacity Act (2005). However, consent had not always been established and best interests' decisions made in line with the legislation. People's nutritional needs were met and people had access to health care when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who they considered caring and patient. Care workers respected people's privacy and encouraged people to maintain their independence. People were able to make everyday choices which were respected by staff. However, staff did not ensure people always received their care in a dignified and timely way.

Is the service responsive?

Requires Improvement

The service is not always responsive.

People were supported by staff who knew them well but staff were not always responsive to people's requests for assistance. People and relatives were involved in planning their care needs. Some care records did not provide staff with clear information to ensure people's care and support needs and preferences were consistently met. People and relatives knew how to make a complaint, and complaints were managed in line with the provider's procedure.

Is the service well-led?

Requires Improvement

The service is not always well-led.

The provider had not maintained the effectiveness of their audits and checks to monitor and assess the quality and safety of the service people received. This meant areas of potential poor practice and areas requiring improvement had not been identified and addressed. People and relatives spoke positively about the service provided and the way the home was managed. Staff felt listened too and valued by a management team who were approachable and supportive.

Craighaven Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to our visit we gathered and reviewed information about the service. This included statutory notifications and the provider information return (PIR) which was sent to us on 9 May 2017. A statutory notification is information about important events, which the provider is required to send to us by law. The PIR is a pre-inspection questionnaire completed by the provider which provides us with a 'snap-shot' of the service, including, what the service does well and improvements they plan to make. We were able to review the information in the PIR during our inspection. We found some of the information provided did not reflect our inspection findings.

We contacted commissioners of the service to find out their views of the service provided. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS. They had no further information to tell us that we were not already aware of.

The inspection took place on 14 June 2017 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience of caring for older people and dementia care.

During our inspection visit, we spent time in the communal lounges and dining areas to see how staff engaged with people who lived at the home. We spoke with nine people who lived at the home and three visiting relatives.

All of the people who lived at the home were not able to tell us, in detail, about their experiences of living at Craighaven Care Home because they lived with dementia. To help us understand people's experiences of the service we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We spoke with eight staff including senior care staff, care staff and an activities coordinator. We spoke with the deputy manager and the company secretary who is one of the directors of the home. The registered manager was on leave on the day of inspection but made themselves available, in the home, at several points during the day.

We reviewed three people's care records to see how their care and support was planned and delivered. We checked three staff files to see whether staff had been recruited safely and were trained to deliver the care and support people appropriate to each person's needs.

We checked examples of quality assurance records such as medicine records, complaints, and the provider's checks to ensure the service operated safely and effectively to provide quality care to people.

Requires Improvement

Is the service safe?

Our findings

This key question was rated as 'Good' at our last inspection. During this inspection we found the provider had not maintained the standards previously demonstrated.

We looked at how medicines were managed. We found training for most staff responsible for administering people's medicines was not up to date and staff's competencies had not been assessed. This is important so the management team can assure themselves staff continue to have the skills and knowledge they need to administer medicines to people safely. One staff member who had worked at the home for more than five years told us, "I did medication training when I first started. I haven't had continual training and I don't recall anyone [management] watching me." The deputy manager told us, "We don't observe staff doing medication. We would expect staff to come to us if they're not confident." They added, "I work alongside staff all the time so I would see if there was a problem."

We looked at six people's medication administration charts (MAR) and found medicines had been administered and signed for at the specified time.

MAR records showed when people had been given 'as required' (PRN) medicine. These are medicines prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. However, we found care plans did not contain information for staff to follow about when and why these medicines should be given. This information is important to ensure people do not receive too much or too little of these types of medicine. We asked staff how they knew when to administer PRN medicines. One told us, "We don't have anything in place [written down] as to why they [people] have PRN medication. But we know them [people] all well so we now when there [PRN medicine] needed."

The registered manager told us some people received their medicines covertly. This is a way of giving medicine in a disguised form. For example, in food and drink. As a result, the person is unknowingly taking medication. We found care plans did not give staff clear information to ensure they administered these medicines safely. For example, one person's care plan informed staff the person's medicine could be crushed and given covertly but did not inform staff how the person's medicines should be offered or disguised. There was no evidence from the pharmacist to show they had been consulted to confirm the prescribed medicines were safe to crush, and whether or not this would impact on the effectiveness of medicines prescribed for the person.

We asked a staff how they supported the person to take their medicine. We were told, "We crush them [medicine] because the GP won't prescribe liquid medication it's too expensive." and, "I don't do it covertly because I try to get them [person] to take it and they do for me."

This meant we could not be assured staff had the skills; knowledge and important information needed to ensure people's medicines were administered safely. We discussed our concerns with one of the directors. They told us they would take immediate action to address the issues.

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

Medicines were stored securely and disposed of safely when they were no longer required. Where people were prescribed medicines that were to be applied directly to the skin, the registered manager had introduced a form containing a body map which clearly indicated where the prescribed item should be applied. Staff told us the new 'forms' were 'really good'.

Staffing levels and the deployment of staff did not always ensure people's individual needs were met. On the day of our inspection there were seven care staff available to support 32 people living at the home. We spent a significant amount of time in communal areas of the home observing how people were being supported. During the morning we observed care staff divided their time between supporting people in their bedrooms and in communal areas of the home. The care people received from staff was task based which meant people had limited or no interaction with staff between care tasks.

On a number of occasions we heard people having to ask staff repeatedly for assistance because staff were not available, or had no time to respond. For example, one person sat in a communal lounge area calling out, 'nurse, nurse'. There were no staff present to respond. After 20 minutes the person had not been seen so we asked the person what they needed. They told us they wanted more food as they had eaten their breakfast and were still hungry. We found a staff member who responded quickly once we had alerted them to what the person wanted.

We shared our observations with the registered manager and one of the directors. The registered manager told us they were disappointed with our feedback as this was not how staff 'usually worked'. The director told us they would be discussing our observations with the registered manager and reviewing why this had occurred on the day of our visit.

During the afternoon we saw care staff were available to respond to people's physical and emotional needs. For example, one staff member spent time with a person, who had recently moved into the home, giving verbal reassurance and comfort because the person was upset. Another sat chatting to a person about their family and family celebrations the person had attended. The person laughed and joked and seemed to enjoy the conversation.

We asked staff if staffing levels were sufficient to meet people's needs and we received mixed responses, "Staffing levels are quite good. Staffing is as it should be today." "We are short of staff…people having to wait for breakfast happens all the time." and, "Sometimes, weekends and mornings are a problem. But, if people phone in sick we can use 'bank' to cover. 'Bank' are care staff with the required skills, who can be called upon to provide cover when needed. The registered manager confirmed bank staff covered planned and unplanned staff absences. They explained this was because, "Continuity is really important for people with dementia. The residents need to know the staff and the staff need to know about the residents."

The provider's recruitment policy and procedures minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to staff working at the home, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to start working at the home until all pre-employment checks had been received by the registered manager.

People and relatives told us they felt safe with care staff who supported them. One relative told us their

family member had 'blossomed' since living at the home because the person felt safe. The relative added, "They [staff] are very trustworthy it inspires confidence in me." We observed people did not hesitate to go to staff when they wanted support and assistance. This indicated they felt safe around staff members.

Staff had received training in how to protect people from abuse and most understood their responsibilities to report any witnessed or allegations of abuse to a member of the management team. Staff knew what to look out for that might be a cause for concern. One explained, "We look out for bruising, anything out of the ordinary. If anything is concerning us we would record it, and inform the manager straight away."

Care staff knew who to contact if they felt their concerns were not taken seriously and people might still be at risk. They told us the provider had a whistleblowing policy which they could use if they thought their concern was not being addressed. Whistleblowing is when an employee raises a concern about a wrong doing in their workplace which harms, or creates a risk of harm, to people who use the service, colleagues or the wider public. One staff member said, "If a manager isn't listening, we might need to contact the police or CQC."

The management team had identified potential risks related to each person who lived at the home. People's care plans included risk assessments to help staff ensure people were safe. For example, one person had been assessed as being at high risk of falls. There was information for staff to indicate the person had forgotten the need to use equipment to mobilise safely due to memory loss. There was also guidance for staff to follow to help keep the person safe if they attempted to mobilise without their walking frame. We observed staff following the instructions detailed in the risk assessment during our visit.

The provider had systems to minimise risks in the environment, such as periodic safety checks of water, fire equipment, and electrical equipment in line with safety guidance. The home was maintained well, and any maintenance issues were dealt with quickly.

Emergency plans were in place if the building had to be evacuated, for example in the event of a fire. Staff demonstrated they understood the provider's emergency procedure and the actions they needed to take in the event of an emergency. We saw people had personal emergency evacuation plans in place. This meant staff and the emergency services had the information needed to be support people in the event of a fire or other emergency situation.

The registered manager undertook monthly reviews of accidents and incidents, including falls. Where incidents had occurred, these had been investigated and action taken to reduce the risk of reoccurrence. The registered manager told us they shared the falls summary with staff in the monthly newsletter. One care worker told us, "The falls information is really good. Especially if you have been off work. You can go back and look at the environment and the reports about the falls."

Requires Improvement

Is the service effective?

Our findings

This key question was rated as 'Good' at our last inspection. At this inspection we identified areas where the home had previously performed well required improvement.

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.

The registered manager had an understanding of the legislation in relation to the Deprivation of Liberty safeguards (DoLS). Records showed the registered manager had made DoLS applications to the local authority because people who lived at the home were restricted from going out alone because it was not safe for them to do so. The registered manager was awaiting the outcome of these applications to ensure people's freedoms were not unnecessarily restricted.

Staff understood the principles of MCA and told us they had received training to help them understand the Act. One commented, "It's about whether or not people can make decisions for themselves. If they can't, someone could be appointed for them. We give day to day choices but it is more for major decisions." When discussing obtaining people's consent before providing care and support, one staff member said, "We [staff] did this in training. Residents [people] could tell you or show you. Like, some of our residents [people] will let you know they are happy for us to help when we ask, by smiling."

However, records showed consent had not always been sought in line with legislation. For example, one person's care plan stated, "If [name] is reluctant to take her medication her GP has given written permission for it to be given covertly." There was no evidence administering medicine covertly had been assessed as being in the person's best interests, or whether the person had the capacity or not to make this decision for themselves. The decision had not been reviewed. A DoLS application had been made to authorise restrictions for the person, but the issue of covert medicines had not been included in the application. We discussed this with the deputy manager, who acknowledged this needed to be properly assessed. They assured us they would take action to address this.

Care records contained information about people's capacity to make decisions and showed MCA assessments had taken place as required. However, where people had been assessed as not having capacity to make certain decisions the instructions about how decisions were to be taken in the person's best

interests were not clear. For example, the registered manager told us one person had a paid representative allocated to them as a result of them lacking capacity to make some decisions. We reviewed the person's care plan and found it was not clear who the paid representative was, or what decisions the provider should contact the representative about. We also found there was no record on the person's capacity assessment and best interests record, of them having a paid representative. We raised this with the deputy manager who agreed this information needed to be made clearer so proper consultation took place when decisions about the person's care and support needed to be made.

Staff completed an induction when they started work at the home. This included working alongside experienced staff and completing some training the provider considered essential to meet the needs of people who lived at the home. One care worker told us they had received, "Two days of care training" when they first started work at the home. Another staff member said, "My induction involved learning about the lay out of the home, all the policies and procedures and getting to know the residents."

The provider's PIR told us in the coming twelve months the home would, 'continue to implement the Care Certificate for all new staff'. The Care Certificate sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment. However, discussions with recently recruited care staff highlighted they were not familiar with the Care Certificate and the 'new employee induction form' did not show any links to the recommended standards. We raised this with the registered manager who said discussions had been held with an external training provider about 'developing care certificate training' but no date had been agreed for this to be implemented.

Since our last inspection the provider had not ensured staff received some refresher training the provider considered essential. For example, records showed some staff last completed 'fire training' in 2013 and 'manual handling' training in 2014. This meant we could not be assured staff had the up to date knowledge and skills needed to support people effectively and safely.

We observed one person being assisted to move from the lounge using a commode on wheels. The person was seated on the commode with their feet unsupported whilst staff pulled them backwards along the hallway. We were concerned this created the potential for the person to catch their feet on the floor and injure themselves. When we asked staff about this practice we were told, "It's what we normally do." We raised our concerns with the registered manager who gave assurance they would speak with staff to ensure a wheelchair with foot rests was used when assisting the person to move.

We spoke with the registered manager and one of the directors about staff training for staff. The registered manager told us they were aware staff training was not up to date. The registered manager told us, difficulties in obtaining cover for shifts within the home meant care staff could not be released to attend training. They added, "I am trying a different approach by organising training at different times of the day to see if staff can attend." The director told us, "We have been trying to get on top of this recently (training).Some training is planned." They told us they would prioritise actions needed to ensure staff training was brought up to date.

Staff told us they had found recently attended training valuable. This included, DoLS, safeguarding and dementia training. One staff member told us, "It [training] has helped me to understand things better." Another commented, "We had the 'dementia bus' here recently. It gave you an insight into what the person might be going through. Everyone is an individual. Some people might see the colour red for example and think of blood. Knowing those things can help you make a difference."

Staff told us they were supported through regular individual meetings (supervision) with a member of the

management team. They said supervision gave them the opportunity to talk about people's needs, as well as their own practice and professional development. One staff member said, "I enjoy supervision. I like to hear if I am doing things right or to ask about things I'm not sure about." They added, "That said you don't have to wait to check something because the manager is always about and they make time for you."

Relatives told us people were supported to access medical professionals on an ongoing and routine basis, as well as when their needs changed or their health deteriorated. One relative said, "The slightest thing and they [staff] are on the phone to the doctor, which is good." A staff member told us, "If we have any worries at all then we ring the doctor and get them to visit." Records confirmed this.

People told us they liked the food provided. One person described the food as 'very good'. People received a choice of food, and food which met their dietary and cultural needs and preferences. For example, the registered manager explained one person did not eat certain meats. They told us, "[Persons name] has dementia so we make sure they are not given anything containing beef as this would be against their beliefs." The registered manager told us they had also researched other items like the gravy the home used to ensure they did not contain any beef by-products.

We observed the lunchtime meal service in different areas of the home. In one dining room we saw a person we had observed eating their breakfast at 11:00 am being assisted to eat their lunch just after midday. We also saw a number of people seated at dining tables who waited almost an hour for their lunch to arrive. There was very limited interaction between people and staff. Staff did not reassure or tell people lunch was on its way, and no attempt was made to engage people in other activities, or to support them to go elsewhere in the home while they waited for their lunch.

In another area of the home we observed staff assisting people to eat by moving from one person to the next which was not dignified or person centred. Before people had finished their main meal desserts were brought to the room and left, some uncovered, on the table. Throughout the meal service staff appeared rushed. One staff member told us, "It's always like this." This meant people were not given the time and support needed to enjoy their meal and make lunchtime a pleasant experience.

Most people were offered a choice of meals. The two meal options were put on plates and shown to people so they could make a choice based on what they could see and smell; instead of relying on their memory of what the dishes were called. One staff member told us, "This works really well especially for the residents who can't tell you what they want."

We shared our observations of the lunchtime service with the management team, who told us this was not what 'normally happened', but that they would look into why it had occurred during our inspection visit

Staff demonstrated a good knowledge of people's nutritional needs and their dietary requirements. For example, they knew who was diabetic, who needed encouragement to eat and who required their food to be pureed. A list of people's individual nutritional needs and food preferences was available to kitchen staff. For example, the list showed one person disliked scampi and another person only liked a small amount of vegetables on their plate.

Requires Improvement

Is the service caring?

Our findings

This key question was rated as 'Good' at our last inspection. During this inspection whilst we saw some positive interactions of a caring nature the overall findings of our inspection indicated people did not always receive care in a dignified and timely way.

People and relatives told us staff were caring and patient. One relative described staff as 'very kind'. They explained this was because staff had been very supportive to the relative who was finding it difficult adjusting to their family member needing to live in a care home. Another relative told us, "Staff make you feel everything is no trouble."

During our visit we observed caring and sensitive interactions between people and staff who lived in the home. For example, one person began to cry while sat in the lounge. A care worker went to the person straight away to ask what was wrong and to comfort them. The person said their legs were hurting, so the care worker reassured the person the painkillers they had recently taken should start to work soon. The staff member left the room and returned with a tissue for the person to use to dry their eyes.

We asked staff what being caring meant to them. One told us, "It is about meeting people's needs, communicating. I try to sit and talk to people, even if it's only one person a day. It's not always possible, but we try and make a few minutes every day and if we all do it, that makes a difference." They added, "We have a few people who are in bed a lot. I like to go in and have a chat even if they don't communicate." We observed one staff member passing a person's bedroom. The staff member stopped at the bedroom door waved to the person and blew them a kiss. The person smiled and waved back.

During the afternoon of our inspection we saw staff had time to sit and talk with people. We observed one staff member sitting next to a person looking through a newspaper and chatting about current events. Another staff member spent time with a person doing a jigsaw puzzle. The person was heard to say, "I like this."

Staff supported people to feel valued. Staff knew people's preferred names and spoke to people in a positive and respectful way. All staff we spoke with and observed knew people well and were able to tell us about people's backgrounds. For example, "[Name] used to play rugby. He loves to reminisce, so we talk about it a lot." And, [Name] was a nurse, she walks around like she's at work. This is important to her."

Staff understood the importance for people's well-being of encouraging them to be as independent as possible. One told us, "We give people as many choices as we can. If people can walk that should be encouraged. If we put everyone in wheelchairs we would be removing their independence." We observed another staff member guiding a person's hands around a glass so the person could drink independently.

Most people were able to spend time where they wished, and could make everyday choices themselves that were respected by staff. For example, we saw some people were up when we arrived, and other people were still in bed. Some people were eating breakfast in the dining room, and other people were eating breakfast

in their room, which was their preference. One staff member told us, "Just because the residents have dementia doesn't mean they shouldn't have choices."

Staff understood the importance of respecting and ensuring people's privacy was maintained. For example, one staff member commented, "We always help people with personal care somewhere quiet, behind doors and with curtains closed. We have a couple of screens we use when the district nurses come round." We observed privacy screens being used during our visit.

However, while people were eating their lunch, we observed two care workers come into the lounge to give people their medicines. One care worker told a person they needed to apply a medicine patch to the person's upper back. The worker apologised to the person for having to do this while they were eating, and proceeded to pull the back of the person's top down slightly and apply the patch.

We raised this with the staff member later, who explained they would not normally be giving those medicines over lunch, and that none of them needed to be given with food. They explained they were delayed that day. They also acknowledged they should not have applied the patch while the person was eating, and should have done this once they had finished in a separate location to preserve the person's dignity.

Staff supported people to maintain relationships with family and those closest to them. Relatives and visitors were welcome to visit at any time. During our visit we observed staff greeting visitors in a warm and welcoming manner. We heard one care worker ask a person if they would like to sit in the garden with their visitor because 'It's a lovely day'. The person agreed. We saw the staff member provided cold drinks for the person and their visitor and said, "If you need anything else let me know. Enjoy your visit."

Requires Improvement

Is the service responsive?

Our findings

This key question was rated as 'Good' at our last inspection. At this inspection visit we found people's requests for assistance were not always responded to in a timely manner and some care records lacked the detail staff needed to ensure consistent care was provided.

Staff were not always responsive to people's requests for assistance. For example, we observed one person ask three different staff members if they could have something to eat and drink. We saw each staff member acknowledged the person's request but did not provide the person with their breakfast. During this time the person was heard to say out loud, "Can somebody come please?" There was no staff presence in the lounge to respond to the person's call for assistance. After 30 minutes of observing we asked a staff member to assist the person with their breakfast which they did.

Some care plans did not provide staff with clear information about people's individual needs. This meant we could not be assured people received consistent care which met their needs and preferences. For example, one person's care plan stated the person could eat and drink independently. Later in the plan, staff were informed the person needed 'assistance from staff with all food and fluids.' Another plan informed staff the person was 'at risk' of developing damage to their skin. To reduce this risk staff were instructed to regularly 'turn' the person whilst they were in their bed. There was no information about the required frequency for these turns, and no records had been kept to demonstrate this had happened.

We spoke with the deputy manager about care plans, and they agreed clearer guidance was needed for staff to ensure people were supported consistently. They assured us they would discuss this with the registered manager and update care plans.

Other plans included information for staff on how people with specific needs should be supported to maintain their health and well-being. For example, one person's care plan told staff the person could become anxious and confused at bedtime. It guided staff to reassure the person by sitting and talking with them. Another plan informed staff the person's first language was not English. We saw the person spent time with a staff member who was able to speak with them in their own language which helped them to be supported effectively.

People and relatives told us care staff who supported them understood their individual needs. One person said, "Oh they [staff] know all about me." A relative told us their family member interacted 'very well with the staff' because the staff understood the person's 'little ways'.

Despite omissions in some care records staff had a good knowledge of people's individual needs, and were able to tell us how people preferred their care and support to be provided. Staff told us they sat with people and their relatives to discuss, and review their care and support needs which helped them to respond to any changes. One relative said, "I sat down with them [staff] and went through (relative's) plan." Records showed staff reviewed care plans each month, with people and relatives being given the opportunity to meet to discuss their needs every three months. However, reviews failed to identify issues we identified in care

records.

Staff told us they had time to read people's care records. One said, "We always read the care plans for someone [person] new. Then if we are told about any changes for other residents we read the plan again." A newer staff member told us they had been given time to read care plans as part of their induction so they could learn about people's needs and preferences before they started providing care and support.

People were allocated 'keyworkers' and these staff members were responsible for overseeing people's care and support. One keyworker told us, "It's my job as a keyworker to make sure I update the care plans if anything changes and to let other carer know. I have to make sure the residents have everything they need and I keep in contact with relatives." This meant people and relatives were provided with a consistent named worker.

People and relatives told us they were supported to maintain their interests and hobbies. One person told us they went out in the provider's mini bus to the shops which they enjoyed. Another person said they enjoyed doing quizzes because 'it kept their brain going'. A relative told us their family member was interested in sport and was encouraged to watch the 'Saturday evening football' in their bedroom which they enjoyed.

A timetable of events and planned activities was displayed in communal areas around the home so people knew what was on offer to them. We saw different activities were advertised on each board, and we did not see any of the activities advertised taking place. However, people's care records included information on activities and events people had participated in. For example, one person's care record stated, "[Name] enjoyed seeing the animals that visited from the zoo." The activities coordinator told us, "The activities plan is not set in stone." They explained this was because people made daily choices about how they spent their time. They added, "We also like to use opportunities the weather present, so if it's nice we will go out to the park."

The activities coordinator told us they supported people with activities five days a week. However, on the day of our visit the coordinator was undertaking other duties within the home to provide cover for staff on leave. They told us, "I'm not doing planned activities today but we do have an entertainer coming in." In the afternoon we saw a singer came to the home to entertain people. A number of people engaged with this, some singing, some tapping their feet. Another person took a tambourine and began to shake it, showing they were enjoying the activity.

The activities coordinator told us they had completed 'specialist' training in activities for people living with dementia and had used this training to make the environment more 'interesting and dementia friendly'. For example, a 'co-op' shop had been developed in one of the lounges which staff used to encourage reminiscence discussion with people. In another area of the home perfume bottles and hairbrushes placed on a 1930's style dressing table provided people with opportunities for tactile stimulation. We observed one person on numerous occasions holding and feeling the bottles. The person also spent time using the hair brush and wall mirror to tidy their hair which their smile said they enjoyed.

Relatives told us they knew how to complain and felt able to raise any concerns with the management team, or care staff if they needed to. We saw the provider's complaints policy was displayed in the home and a suggestion book was kept in the front reception. A staff member explained the suggestion book was for 'anyone' to use if they wanted to make a comment. No comments had been recently made.

Staff told us they would support people to make complaints. One said, "I would write down what the

complaint was. Then, I would reassure the person and see the manager or the deputy so they can deal with it." Another told us, "If I can't help by sorting it I tell them [people] I am going to refer it to the management and they will sort things."

The home had not received any formal complaints in the last 12 months. Records showed the registered manager recorded and looked into minor concerns people raised.

The registered manager kept a record of compliments received by the home. We saw numerous cards from relatives 'thanking' staff for the care and support provided to their family members.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection this key question was rated as 'Good'. During this inspection we found the provider had not consistently met their regulatory responsibilities and had not ensured checks to monitor the quality and safety of the service remained effective.

We found, audits and checks to assess and monitor the quality and safety of the service provided had not been consistently completed. For example, medicines management had been audited once during 2017. This meant the provider had not assured themselves staff remained competent to safely administer medicines to people and medicines were being administered covertly without seeking the required specialist advice and the documentation.

Some auditing processes were not sufficiently detailed to enable them to be effective. For example, the audit tool used to check care plans showed the date the plan had been reviewed and by whom. There was no further detail to confirm care plans were up to date, issues had been identified and actions taken. We saw the latest audit contained care plans we had reviewed but the inconsistencies we found had not been identified or addressed. This meant staff did not have accurate information about people's needs and wishes to enable them to provide care and support safely.

The lack of auditing and their effectiveness meant the provider was not identifying areas where improvements were needed and was not ensuring the service remained safe, responsive and well managed.

The arrangements the provider had in place for quality monitoring had not identified staff were not always available at the times people needed them. We observed this during our inspection, for example during at meal times.

The provider had not ensured that staff had opportunities for refresher training. Records showed staff training was not up to date in areas the provider considered essential. The provider's '2017 inspection plan' showed they had identified the need for staff training in nine specific areas including, 'fire awareness', 'medication management' and 'manual handling'. One of the directors confirmed report writing and manual handling was planned for July 2017. However, other training had not yet been agreed. This meant the provider had not taken action to ensure staff had the necessary skills, and knowledge to undertaken their work competently and safely.

One of the directors told us, "We [management] have not had a great time this year which has caused things to slip." They explained this was due to having to deal with 'complex' staff related issues which had now been addressed. They added, "We are more than aware of our short failings and know what improvements need to be made. These things will be addressed. We always strive to give the best quality care to our residents".

This was a breach of Regulation 17 (2) (a) (f) of The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Good Governance.

Relatives told us the quality of service provided was good and in their opinion the home was well managed. One relative described the registered manager as 'outstanding' because the registered manager had a clear understanding of their family member's needs which were met 'properly and efficiently."

The provider invited relatives to share their views about the home and areas where improvement could be made through an annual survey. Records of the latest survey completed in May 2017 showed relatives were satisfied with the service provided. All respondents stated they felt a high standard of care was being provided and found the registered manager to be approachable. No suggestions for improvement had been made. The registered manager told us the staff survey was due to be issued later in the year. They added, "Staff know they can talk to me at any time and they don't have to wait for a questionnaire."

The home had a clear management structure; this included directors of the home, the registered manager, the deputy manager, the care team leader and senior care staff. Care staff knew the management structure and understood who to report concerns to. The registered manager told us they were supported by the provider through regular visits to the home and telephone contacts to discuss any area of concern or areas for development. The registered manager said they also attended a 'provider forum' arranged by the local authority and a recently formed local provider group. They told us this created the opportunity to meet other registered managers to share ideas and keep up to date with any changes in the local community.

One of the directors told us they used their weekly visits to the home to speak with people, relatives and staff and to undertake checks to ensure the home was well maintained. They said, "I visit two or three times a week at different times so I can meet different people and observe in the home. I like to do a big walk around every so often. I go around room by room." Records of a 'walk around' completed by this director in February 2017 identified areas for improvement. We saw these were being addressed. For example, the provider had approved a new wall for the front of the home which was being built on the day of our visit. New flooring had been laid in some hallways and plans had been agreed for the inside of the home to be redecorated. We observed this director engaging with people, relatives and staff in a familiar and friendly manner.

Staff told us they felt supported by the management team and enjoyed working at Craighaven. We were told, "What I like is you can talk to them [management] and the manager will listen to your point of view.", "Everyone works as a team. There is a friendly atmosphere that's why I enjoy working here." and, "[Registered manager's name] is very understanding. She helps you out with work and personal issues." Staff told us the provider operated an on call rota. This ensured people and staff were supported outside normal office hours or in an emergency. One care worker told us the on call system was 'good' because they [management] responded 'straight away'.

Staff told us they met regularly as a staff team. One staff member said, "It's difficult to get everyone together at the same time so [registered manager] does one in the afternoon and one in the evening so you can choose which you go to." Staff told us they valued these meetings and saw them as an opportunity to discuss any concerns or ideas for their own and the home's development.

Staff told us they felt their opinions were valued and listen to. One staff member gave the example of suggesting having wet wipes available to enable people to 'freshen up'. They said, "The manager thought it was a good idea and now we have them all the time." The registered manager told us, "What I love about my staff is that they think outside the box". They added, "I listen to staff's ideas and support them to take ownership for them."

Staff told us, and we observed there were systems in place for staff to share information through a handover at the start of each shift and a communication book. This gave staff the information they needed to support people and respond to any changes in people's physical and emotional needs. One staff member told us, "The handover is really important particularly if you have been on leave. It makes sure you know what's happening and what the residents need."

We saw the registered manager produced a monthly newsletter which was issued to each staff member. Staff told us they found the newsletter 'informative'. The latest newsletter included information about staff training, infection control, activities and a falls analysis for the month of May.

We asked the registered manager about their responsibilities for submitting notifications to us. This was because the registered manager had not informed of an incident which had been investigated by the local authority safeguarding team and the police. A notification informs us of events that affect the service which the provider is required by law to tell us about. The registered manager told us, "It was my mistake. I was under the misapprehension that I did not have to send one." The registered manager was able to demonstrate they now understood their legal responsibility for submitting statutory notifications. We did not see any further information during our inspection which we should have been notified about.

Providers are legally required to display the ratings we give them within 21 days of receiving our final inspection report. A 'rating poster' showing the home's latest rating from our inspection in 2015 was displayed in the front reception area of the home. However, the provider had not added the rating to their website. The provider addressed this during our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (2) (g) The provider had not ensured staff responsible for the management and administration of medicines were suitably trained and competent. We could not be certain people received their medicines safely and as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (2) (a) The provider was not conducting regular audits of the service to assess, monitor and improve the quality and safety of the service. 17 (2) (a) The provider had not ensured medicines were administered in line with nationally recognised guidance. (2) (f) The provider had not ensured their audit and governance systems remained effective.