Guild Care

Haviland House

Inspection report

20A Robin Road
Goring by Sea
Worthing
West Sussex
BN12 6FE

Tel: 01903528500
Website: www.guildcare.org

Date of inspection visit:
09 August 2016
10 August 2016

Date of publication:
28 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 10 August 2016 and was unannounced.

Haviland House is a home registered to provide nursing and residential care for up to 60 people with a variety of health needs, including people living with dementia. At the time of our inspection, 57 people were living at the home. Haviland House is a modern, purpose-built nursing home situated within a residential estate to the west of Worthing. The home comprises five x 12 bedded suites housed on the ground, first and second floors: Angmering, Bramber, Clapham, Durrington and Elmer. Each suite has two separate living rooms, a dining room with kitchenette, assisted bathroom and all rooms are of single occupancy with en suite facilities. Gardens are well maintained and provide seats and shady areas for people to enjoy.

At the time of our inspection, there was no registered manager in post. The acting manager was due to be replaced by a permanent manager when their employment commenced on 5 September 2016. 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 times, staff were not deployed flexibly to meet people's needs in some parts of the home which placed people at potential risk. Gaps within staffing rotas were filled by agency staff. Staff felt that staffing levels were an issue and the management team was aware of this; new staff were being recruited. Only a small number of staff had received training on the Mental Capacity Act 2005. We have made a recommendation to the provider that all care staff should be trained to understand their responsibilities under this legislation. Staff had been trained in all essential areas and received supervision as needed, although the regularity of 1:1 meetings had slipped recently. Group supervisions and staff meetings took place. New staff studied for the Care Certificate, a universally recognised qualification.

People were supported to have sufficient to eat and drink and their risk of malnourishment had been assessed. Catering was provided by an external organisation. Some staff were not always sensitive to people's assessed needs and risks during the lunchtime periods we observed at inspection. Some staff displayed a lack of empathy when discussing people's needs with other staff. However, the majority of staff were kind, understanding and supportive of people and treated them with dignity and respect. People had access to healthcare services and professionals. Care plans were detailed and provided comprehensive advice and guidance to staff on how to meet people's needs and preferences.

People's risks had been identified, assessed and were managed appropriately. Arrangements were in place, and staff were trained on the action to take, in the event of an emergency such as fire. People's medicines were managed so they received them safely. A number of safeguarding concerns had been raised recently and the provider was working collaboratively with the local safeguarding authority to ensure these were investigated thoroughly and managed appropriately.

The environment at Haviland House had been designed to meet the needs of people living with dementia and to provide stimulation and a homely atmosphere. However, we observed one area of the home which the provider had also identified as an area for improvement in a corridor on one suite. Some activities had been organised for people in parts of the home, but overall, during the inspection period, there was a lack of regular, inspiring activities to engage with people. The provider was in the process of recruiting staff who would oversee people's health and well-being and who would provide a person-centred approach, based on people's preferences, hobbies and interests.

A range of audits was in place to monitor and measure various aspects of the service. A Continuous Improvement Plan identified ways of monitoring and improving new systems which were still being embedded. The audits had identified several areas for improvement, however, improvements had not always been carried out where issues had been previously identified.

People and their relatives were asked for their views about the service through questionnaires and surveys. Feedback generally was positive. 'Family and Friends Meetings' updated people and their relatives on what was happening at the home and were a forum for receiving comments and questions.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this 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

Some aspects of the service were not safe.

Staff were not always deployed flexibly to ensure people's needs were met and they were safe. The service relied on the use of agency staff to meet any shortfalls in staffing levels.

Premises were managed safely and people's risks relating to the environment and to their personal care needs had been identified, assessed and managed safely.

Medicines were managed effectively.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Only a small number of staff had received training on the Mental Capacity Act 2005 so the majority of staff did not understand their responsibilities under this legislation. However, staff had completed training in other essential areas.

People were supported to have sufficient to eat and drink. However, their needs were not always recognised or managed sensitively by some staff who were supporting them. People had access to a range of healthcare professionals and services.

The environment had been planned with emphasis placed on meeting the needs of people living with dementia. Some parts of the home were not conducive to people's needs and information on display was not always accurate or updated.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well. They were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

There was a lack of organised activities that provided mental stimulation for people within some suites in the home.

Care plans provided detailed information and guidance to staff on people's care needs and preferences.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Areas for improvement had been identified by the provider through a range of audits, however, action was not taken to address some areas in a timely fashion.

The service was without a registered manager, although the current acting manager was in the process of registering with the Commission. A new permanent manager had recently been recruited.

People and their relatives were asked for their views about the service through regular meetings and annual surveys.

Haviland House

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.

The inspection took place on 9 and 10 August 2016 and was unannounced.

One inspector, a nurse specialist and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including 13 care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day of our inspection, we met with eight people living at the service, spoke with three relatives and a friend of a resident. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the head of nursing and quality, the deputy manager, the health and well-being team leader, two team leaders, a senior carer, six care assistants, two registered nurses and an administrator.

Haviland House registered with the Commission in December 2014 and has not previously been inspected.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were assessed based on people's care needs. There were sufficient numbers of staff on duty at the home, but staff were not always deployed flexibly to meet people's needs, keep them safe and protect them from harm. This was particularly evident in one suite. During the day, two registered nurses were available and at night, one registered nurse was on duty at the home. Generally, a team leader was in charge of each suite and was assisted by at least three care staff. However, maintaining consistent staffing levels had been problematic and the head of nursing and quality told us that recruitment of suitable staff was an ongoing issue, especially in relation to recruiting registered nurses. At times, reliance was placed on agency staff to deliver care to people living at the home.

A relative told us, "The majority of the time there is insufficient staff and at weekends there is no management cover. You don't know who the team leads are on a day to day basis" and added, "The quality of the care is dependent on who is on duty". They went on to describe a situation the previous weekend where a sensor mat alarm had sounded for about 10 minutes before staff came to check what was happening. Another relative confirmed their family member was well looked after and that staff were, "Quite good", but added, "I don't think there is enough of them. He [referring to family member] needs three staff to sort him out. One time I said, 'Could you change him?' as he was smelling and they said he would have to wait until someone comes back". However, a third relative told us, "Yes, she's in a secure environment and she can't come to any harm by wandering off. There seems to be more than enough staff available to make sure she's safe". Views on staffing levels varied according to which suite was being referred to by relatives. After the inspection, the provider stated that management were available at weekends and were 'on call', so that staff had access to senior staff as needed. We were also told that managers were available seven days a week if required.

On the first day of our inspection, we observed one person in one suite stop in the corridor and start to soil themselves. One staff member, who had been busy supporting another person, called out to other staff stating that help was needed. By the time staff appeared, the person had soiled themself and the floor. One member of staff ran to get a commode, then took it away again as another member of staff guided the person to the bathroom. Staff were panicking about the situation and that it had occurred, and been observed, during inspection. One staff member could be heard saying, "[Named person] smudged it all over the place; we need to get the cleaner". The mess on the floor was dealt with and the area cleaned appropriately. People and any visitors must have heard what had happened as staff talked loudly throughout, with a lack of dignity and respect for the person involved.

Whilst all this was happening, another person emerged from their bedroom with their trousers halfway down their legs and something wrapped around their feet. A staff member approached him and said, "Why have you got pillowcases on your feet?" and added, "I can't leave you as you might fall over". Staff then tried to untangle the person's feet and called for assistance, but no-one came. The staff member continued to try to untangle the person's feet from the pillowcases so that the person fell back and appeared to bang his head as he cried out. The staff member summoned assistance when they rang the call bell and help arrived promptly. The registered nurse arrived and the person became increasingly distressed. The head of nursing

and quality also arrived on the scene and told everyone to leave as there were at least five staff around the person. Medical attention was provided to the person and they were monitored at regular intervals by staff to ensure no long-term injury had been sustained. These incidents show that staff were not always suitably deployed or experienced to meet the needs of people in a timely manner. After the inspection, the provider told us that the incident was recorded and reported appropriately and provided us with a copy of the incident form that corroborated this.

We asked staff about staffing levels at the home. One staff member said, "They try and keep the same staff on the same suite. I think sometimes we could do with more staff". Another member of staff told us that staffing levels were, "A big, big issue. We don't get time to sit and chat with them or do activities with them. We don't know who we're going to be working with from one day to the next". Staff told us that agency staff who had not worked at the home before needed help and support from care staff and that this took time away from caring for people. A team leader said, "It can be heavy going, even with just 12 residents". They felt that the issue was being resolved by management and said, "We need regular staff, so we can have continuity, although it's much better than when I first started". Some staff felt that staffing at weekends could be an issue. One staff member said, "Weekends do seem to be a problem" and that gaps in staffing rotas were frequently filled by agency staff. A staff member said that, whilst there should be a team leader and three care staff working on each suite, there had been occasions when this level had dropped to one member of care staff, one agency care staff and a team leader. They told us, "Today's been a good day and I've felt safe with the staff on duty today". They went on to say, "I think the workload has definitely increased. We just get on and do it. There sometimes isn't enough hours in the day. I will stay and work extra hours if I need to. I want to leave here knowing I've done what I'm meant to have done".

We discussed our concerns with the head of nursing and quality who was aware of the incidents that had occurred during our inspection. They explained that, in one unit which accommodated a large number of people with behaviours that might challenge, staffing levels were sufficient, but there was a lack of experienced staff on duty that day, as new staff had recently joined the team. In addition, no team leader was on duty that morning to provide appropriate leadership and oversight. After the inspection, we were told that a registered nurse, working across two suites, would have provided appropriate leadership and oversight. Staff shifts and rotas were managed by an administration team responsible for rota management at this home and at the provider's other homes. Staffing levels were re-assessed at the end of staff shifts and discussed at handover meetings. Staff could then be deployed appropriately and flexibly. We checked the staffing rotas. Each floor had a registered nurse who would provide nursing support across the suites and, if needed, to the ground floor suite. We observed that the registered nurse on duty at the time of the incidents appeared stretched with their responsibilities as no team leader was on duty in the morning. This resulted in the morning medication round being completed later than usual. Some people could not then be offered pain relief medicines at lunchtime, because insufficient time had elapsed since their last dose and it would have been unsafe to administer a further dose within that time period. However, during the later shift, the presence of a team leader resulted in a positive change. One staff member was employed as a 'flexible worker' which meant they could be allocated to work in any of the suites as needed. This enabled care staff to be redeployed to any unit as needed.

The above evidence shows that staff were not always deployed flexibly to make sure that people's care and treatment needs were met. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had not always been protected from avoidable harm and abuse, but the provider had responded appropriately in line with safeguarding procedures and had met their responsibilities in line with Sussex Safeguarding adults policy and procedures. A number of issues relating to allegations of potential abuse

had been raised by relatives and by the provider and were notified to the Commission. These had been fully investigated by the provider and the local authority safeguarding team had been informed and was working with the provider in identifying any actions that needed to be taken to prevent reoccurrence. We discussed the safeguarding incidents with a representative of the local safeguarding authority. They told us they were happy with the scope of the investigation and that further meetings would be organised to discuss any ongoing issues and how these should be addressed. We asked a relative whether they had any concerns about the safety of the home and whether their family member was happy. They told us, "As much as she can, she's happy here. She is safe and secure and well looked after".

We asked staff about their understanding of safeguarding and what action they would take if they suspected people were being abused. One staff member said, "It's about keeping the residents and me safe" and gave an example of ensuring that one particular person always had their walking frame to hand, to prevent the risk of falls when walking. They told us that if they saw a person had unexplained bruising, they would report this to a senior member of staff straightaway so that action could be taken. Another member of staff described different types of abuse such as neglect through malnourishment and physical abuse. They described a situation where one person may try to harm another and said, "We try and calm the situation and move them away. We would sit down and have a cup of tea with people".

Safe recruitment practices were in place and staff files we checked confirmed this. Before staff commenced employment, two references were obtained to ensure their suitability for the post. The provider also undertook checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and help prevent unsuitable staff from working with people.

Premises were managed safely. Exit and internal doors were clearly identified with fire escape routes. At reception, there was a diagram of the layout of the building to support easy navigation and access within the home. Call alarm panels were affixed to walls throughout the building to indicate when people needed assistance from bedrooms and communal areas. The corridors were wide and kept clear of obstructions to allow free movement and evacuation in the event of an emergency. Additionally, equipment was placed at the top of staircases to permit ease of evacuation of people. Personal Emergency Evacuation Plans had been drawn up for people and were contained in their care records. These provided advice and guidance to staff on what action to take should the building need to be evacuated. Staff were trained in fire safety and fire alarms were tested regularly.

Generally, people's risks were identified, assessed and managed appropriately. However, during the lunchtime period, we observed nine people were supported by four staff in the dining room of one suite. Two staff were supporting two people to eat food that had been pureed, as they were at risk of choking or had difficulty with swallowing. We observed another person started to cough, which could have indicated they were choking, and staff made their way over, patted the person on the back and suggested that, before they ate anymore, they should chew and swallow what they had in their mouth. The person was then handed a spoon. A little later, the person started coughing again. Staff went over to them again and rubbed their back as the person was regurgitating food. The staff member told the person to put their spoon down, then started to clean them up with napkins. A little later, the person started to cough a third time. Staff attended promptly, cleaned them up and rubbed their back. The staff member then noticed, when the person had nearly finished all their meal, that their food was not mashed sufficiently to prevent the risk of choking and mashed it into a softer consistency. The person then continued to eat without any further incidents. We checked the care plan for this person and their risk of choking had been assessed. The risk assessment showed that choking was a risk if the person ate too quickly and that they required their food to be mashed to a soft consistency to mitigate the risk. Staff had not supported this person in line with their assessed risk.

Risk assessments were detailed and provided comprehensive advice and guidance to staff. Assessments within people's care records included the use of bed rails, management of diabetes and wound care, moving and handling and Waterlow – a tool for assessing people's risk of developing pressure ulcers. Each person had their own manual handling slings for individual movement from bed to chair and separately for bathing. The mobility devices were all checked and dated within the safety period.

People's medicines were managed so they received them safely. Medicines were stored securely in trolleys or within a medicines room. Medicines that required refrigeration were stored at the appropriate temperature. There was a daily handover audit on each shift for some medicines. The medication administration record (MAR) for each person was well documented, showed the person's photograph and that medicines were administered safely by trained staff, either registered nurses or team leaders. All staff responsible for the administration of medication had received face to face training and their competence assessed in practice before being allowed to administer peoples' medicines. Medicines were dispensed through a monitored dosage system and blister packs. People who received medicines covertly, that is without their knowledge, had a signed care plan with detailed information that justified such an approach. Medicines that were administered 'as required' were given according to the provider's medicines policy. Where pain killers, such as analgesics, had been administered, a separate record was attached within people's daily records. Medicines were administered safely. Medicines audits were completed which included checks on ordering and receipt of medicines, fridge temperature recording, competencies of staff to administer medicines safely and daily checks of MARs.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The staff training plan showed that a very small number of staff had received training on MCA and DoLS and staff we spoke with did not have a good understanding in this area. We discussed this issue with the head of nursing and quality, who agreed it was an area for improvement. However, staff did tell us how they supported people to make day-to-day decisions and choices. A relative talked about their family member and said, "Because she doesn't have capacity to make safe decisions, they support her to be as independent as much as she can".

We recommend that the provider ensures that all care staff complete training on MCA to enable them to understand their responsibilities under this legislation.

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. Capacity assessments had been completed for people living at the home. Where they had been assessed as lacking capacity, DoLS applications had been completed and sent to the local authority. The majority of applications were still outstanding and were waiting to be processed by the local authority.

People were supported to have sufficient to eat, drink and maintain a balanced diet. People's risk of malnourishment had been assessed using the Malnutrition Universal Screening Tool, a tool specially designed for this purpose. Care records documented people who were at risk through regular weight monitoring and the completion of food and fluid intake charts. Plans were in place to inform staff of the action to take to support people who had regularly lost weight. For example, some people were offered additional snacks and milky drinks and their meals were fortified to provide a higher calorie intake. If people's weight did not increase after a month, then a referral was made to the GP or dietician for advice and guidance.

An external organisation had been sub-contracted by the provider to meet the catering needs of people living at the home. We observed people eating their lunch in two suites on the first day of our inspection. Lunch was served from heated trolleys to each suite between 12.00 noon and 12.30pm. No menus, either in pictorial or written format, were available to people in these suites, so staff told people about the food choices on offer. Tables were nicely laid with cutlery, tablecloths and paper serviettes. We observed one person was assisted by staff to sit down at the table and that they became distressed, lashing out at staff. Staff bent down and talked quietly with him. He was asked what he would like to drink and offered a choice of blackcurrant, lemon or orange squash. Another person was asked what they wanted to eat and was offered a choice of Lancashire hotpot or vegetable pie; they chose the pie. This was served up and put in

front of him, whilst another member of staff shouted across, "He needs a plate guard"; this could have been managed more discreetly. Generous portions were served and one person asked for a small portion. This was served up on a side plate, to which the person responded, "Is that the best that you can do?" The food was not presented attractively. This person thought they had to pay for their meal and was reassured by staff that this was not the case. They were eventually encouraged to their room to eat their lunch. We observed one person called out twice saying, "Help me" and staff asked them what was the matter. The person then said, "I can't get it on the fork", so staff asked them, "Would you like a spoon?" which the person accepted. Two people had their food pureed and their meals were separated out into the different food groups; staff supported these people with their meals. One person was asked by staff if they wanted rhubarb and orange crumble with custard. Immediately another staff member interrupted and said, "He can't have any as he's diabetic, he has strawberries. I have to go to the kitchen and get some". This was insensitive to the person and their medical condition as the comment should have been made more discreetly and unobtrusively. A male resident arrived a little later for their lunch and we saw staff place a frilly, rose patterned apron across his front. The resident was not asked for their permission or whether they were happy to wear an apron that was feminine in design. We discussed this issue with the head of nursing and quality who later fed this back to the staff involved.

In another suite, people were enjoying their lunchtime meal. One person kept falling asleep at the table and a staff member said kindly, "You can't eat with your eyes shut!" The person was asked if they might prefer to have a rest in their room and their lunch could be saved for later. However, the person said they would rather eat their lunch now and this was arranged. People were encouraged to eat their meals by staff. One staff member referred to a person and their lack of appetite when they were admitted to the home. They told us this person would eat anything with eggs, but now they were eating a more healthy and balanced diet. They said, "It just takes that little bit of encouragement. She'll now eat mostly anything and champagne!" We observed one person was asked by staff what they would like for dessert and they were offered the crumble with custard or yogurt. The person appeared to be confused by the choices offered, so the staff member repeated them again and for a third time. The person had difficulty in understanding what was being offered to them. It would have been helpful if the staff member had brought a bowl of crumble and a pot of yogurt to the table, which would have provided the person with a visual reference of what was on offer, thus aiding them to make an informed choice. Generally, staff were supporting people in a kind and friendly manner, attending to their needs and ensuring that people had what they wanted, for example, an extra helping of gravy or salt and pepper.

Haviland House is a purpose-built nursing home which opened in December 2014. Much advice had been sought on how to adapt the home to support the needs of people living with dementia and people with nursing or residential care needs. Within each suite there were themed rooms. For example, a sitting room had been equipped with items relating to sewing and knitting and contained a dressmaker's dummy, an old-fashioned manual sewing machine and knitting patterns. Squares or muffs had been knitted which provided different textures for people to feel and touch, with sparkly materials or bells that jingled. Another room had a nautical theme, with patterned wallpaper and a world map on display. People's bedroom doors were painted different colours which aided people's orientation around the home. Corridors were wide and included handrails to support people as they mobilised in the suites. People could bring their own furniture and personal effects with them when they were admitted. A member of staff said, "It's about making this place how it would be at home". A hairdresser's salon was available to people on the ground floor. One suite had a roof garden and people had helped to grow tomato plants and flowers in tubs. We observed one person was watering the garden which they enjoyed doing. Gardens at the rear of the home were tidy and well maintained. 'Memory Lane' contained a red telephone box and there were spaces for people to sit and relax. The gardens were cheerful and inviting and contained a variety of colourful plants and flowers, using colours and perfumes of flowers to good effect. A volunteer enjoyed working in the garden and, in addition

to maintaining flowering plants, had grown vegetables which were on sale in the reception area of the home. However, on the day of our inspection, which was sunny, few people seemed to have taken advantage of going out into the garden.

'Charlie's Potting Shed' was situated at the end of one corridor and contained a workbench, empty plant pots, garden tools, an artificial geranium and an old-fashioned radio. Sadly, the radio did not work. In another suite, we observed a bookcase on top of which was a half-dead spider plant and information relating to 'What's on – September-December 2014' and a visitor's guide to Faversham dated 2014. It was difficult to see what relevance this information would have had for people living in the suite. An audit undertaken by the provider had already identified this issue as an area for improvement in April 2016, however, no remedial action appeared to have been taken to make the area more inviting or conducive to the needs of people living with dementia. We observed that a notice in the dining room of one suite showed a date of 6 August 2016 (Saturday, with sunny intervals) when the date was actually Tuesday 9 August 2016. This would have been confusing for people living with dementia as the information was inaccurate. In Clapham suite, Tuesday's menu was still left up on the board during the day on Wednesday which did not enable people to make choices..

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. In addition to the Care Certificate, new staff followed an e-learning programme which had been introduced by the provider and an induction programme. Staff were required to complete essential training in dementia awareness, moving and handling, fire safety, safeguarding, infection control, health and safety and medication awareness. In addition, staff were encouraged to study for qualifications, such as a National Vocational Qualification in Health and Social Care, which is a work-based award and externally assessed by a local college assessor.

We asked staff about their training. One staff member said, "We have all the necessary, like moving and handling, food safety, safeguarding, dementia and infection control". A team leader confirmed they had completed all essential training and added, "It's quite hard to fit in because some are whole days". Some staff had completed a Certificate of Dementia Awareness, a new course offered by a local college. Topics covered communication, person-centred planning, challenging behaviour, physical health in dementia and anti-psychotic medicines. We talked with two registered nurses about working at the home and they told us they felt supported and listened to by the manager. They had support with continual professional development and there was an ongoing revalidation programme to ensure their registration with the Nursing and Midwifery Council was upheld.

Staff confirmed that they received supervision meetings, either in the form of group supervisions or 1:1 meetings. Staff files confirmed that staff received 1:1 supervision meetings with records of these meetings, but the regularity of these meetings had slipped recently. A minority of staff had completed annual appraisals. This had been identified as an area for improvement by the provider. Staff meetings took place, usually as separate meetings, for each suite. One member of staff told us they attended a 'suite meeting' every week and monthly meetings for all staff. They said, "I find them useful, especially suite meetings. We discuss what's working and what's not". Another member of staff, who worked on Bramber suite, said it was part of the team leader's role to organise staff meetings, adding, "It's been a bit of a shambles over here" [referring to Bramber]. Separate staff meetings were held for night staff, registered nurses and team leaders and records confirmed this.

People were supported to maintain good health and had access to a range of healthcare professionals and services. One person's friend who was visiting the home described an occasion when staff supported the person to attend a hospital appointment and that some staff even came in on their day off, so the person would have a staff member who knew them well. A GP from a local medical practice visited weekly and people were also supported by an allocated community psychiatric nurse. The provider worked closely, and liaised with, the local authority's Dementia Crisis Team and Dementia In-Reach Team. People had access to professionals from a multi-disciplinary team, including speech and language therapists, physiotherapists and dieticians. Visits from professionals were recorded in people's care plans.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Staff were patient with people and supported them to be as independent as possible. Staff were helpful and demonstrated compassionate care. Three people told us they were happy with the care they received and a relative agreed, although they added that they thought a lot of good staff had left in recent months. A friend who was visiting one person at the home described staff as, "Respectful and very helpful, who make themselves available to speak to you". Visitors to the service were not restricted in accessing the different parts of the home as they were provided with a key fob which operated the lift doors and allowed access to doors leading to the stairs. A relative had mixed views and said that staff would visit their family member in their room and say 'hello', without announcing who they were. This was an issue as their family member could not see very well.

We observed that people were treated kindly by warm and friendly staff who knew people well. A team leader said, "Staff do know people really well" and added that new staff were working hard to get to know people, as there had been a bit of a staff turnover recently. They told us, "I love the residents and I think I have a good rapport with the staff here". We observed one person, accompanied by a member of staff, walking along the corridor towards the dining room at lunchtime. We overheard the person say to the staff member, "Don't you think it would be better if I died off?" (We later heard that this person regularly said this.) The member of staff responded in exactly the right manner, saying, "No darling, let's go and have some lunch". The person appeared pleased with the response and made their way happily towards the dining room.

People were encouraged to express their views and to be involved in day-to-day decisions and choices. A staff member told us that people could choose when to get up or go to bed and said, "Some people like to get dressed for bed early and then watch the TV together in the evening". Another member of staff said, "We absolutely promote choice" and a team leader told us, "It's about treating people as individuals". A relative told us that their family member's care plan was drawn up in January and that they had not been involved in any reviews since then. Another relative referred to the care plan and said, "No, they [staff] just read it through to me". In the Provider Information Return (PIR), the manager had identified this as an area for improvement, following feedback from some relatives that they were not informed of changes to their family members' care plans. As a result, people were allocated named staff whose responsibility included contacting families on a regular basis to ensure they were kept informed and updated. On the first day of our inspection, a relative told us, "We had a discussion about her care plan when she was admitted".

People were treated with dignity and respect. When people received personal care from staff, a sign was put on their bedroom door to indicate staff and visitors should not enter. A relative told us, "They send me out during personal care".

Requires Improvement

Is the service responsive?

Our findings

Limited activities were available to people and were not consistently offered in all suites at Haviland House. Where activities had been organised, these were enthusiastically run by staff members who encouraged the participation and engagement of people living at the home. For example, we observed a sing-a-long activity was enjoyed by 13 people in one of the sitting room suites. People joined in with singing songs from musicals and the words had been printed out and handed to people who could not remember the lyrics. People were enjoying the activity and drinks and chocolate cake made the activity special. In another suite, we observed people were supported by staff to ice and decorate gingerbread men, which they appeared to like doing and then enjoyed eating. A volunteer visited the home twice a week and took people out in a pool car, accompanied by care staff. A 'bar', selling soft and alcoholic drinks was set up once a month on a Wednesday in the Ashmount Lounge. When they had time, in some parts of the home, we observed staff sitting with people and engaging in conversation or an activity such as cards or dominoes. One staff member said, "This morning they're playing Bingo, it should be nice". They added, "People love to sit in the garden. We try and take people out. I do as much as I can".

The provider had decided to remove the role of 'activities co-ordinator' and replace this with staff who would adopt a holistic approach based on people's health and well-being. We spoke with the health and well-being team leader, who felt a balanced, co-ordinated and person-centred approach was needed. They told us, "We're thinking towards implementing well-being champions who will initiate every individual's well-being on each suite". They talked about people in one suite and how the majority enjoyed music, which was a 'connecting factor'. Activities would be planned that were based on people's individual likes, interests and hobbies. However, this was still 'work in progress'. A relative told us, "Activities are haphazard, so Dad's needs are not met regarding stimulation. They don't think, 'Oh he's blind, shall I read to him'. It's the inconsistency". They added, "I talk about my Dad's life and people [staff] say, 'That's interesting'. If they had read his case history they would know this". We talked with one person who had limited conversation, but talked about conkers, climbing trees and how to get the best conkers to beat your opponent. However, he also kept saying that he did not know what to do next. We asked if he was happy living at the home and he said, "It's nice – nice views of everything". At inspection, we observed that people living in Bramber suite had little to engage with and a lack of mental stimulation. No activities had been organised when we visited and there was an air of boredom. A member of the inspection team observed that people were left on their own for a while in the sitting room with music playing from the 40s and 50s. When staff came into the room, they engaged in cursory conversation with people which was task led and centred on whether people wanted a drink or not. The lack of activities could impact on the mental wellbeing of people living with dementia and potentially exacerbate negative behaviours in people, because they were bored and lacked mental stimulation.

We recommend that the provider organises a programme of regular activities that meets people's interests and is accessible to everyone living at the home.

People's care plans were kept electronically and updated on a computer system. Each person had a summary care plan as well as further detail which included information relating to their personal care,

medical history, mobility and transfers, medication, pain management, communication, maintaining a safe environment, continence, skin integrity, sleep and resting and end of life care. Staff could access people's care plans easily and recorded daily updates on the support they had given to people. Care plans included people's goals and the interventions required from staff to help them achieve their identified goals. Care plans were reviewed regularly and updated as needed. For example, we saw one care plan had been updated twice in January, then again in February and April. People's preferences, likes, dislikes, daily routines, hobbies, relatives and friends were included in their care plans. A member of staff referred to the care plans and told us, "There are hard copies too and I like to look on [named software program] because they have people's likes and dislikes. If I don't know someone, that's the first place I look". We saw that the care plan for one person, who had been admitted in February 2016, was still incomplete and had not been finalised in electronic format. This meant that no hard copy of the care plan was available. We discussed this with the head of nursing and quality who provided a copy of the individual's risk assessment and supporting pre-admission and on-going assessment tool that staff were referring to, to inform care. They confirmed that the care plan would be finalised as soon as possible.

We examined the complaints log which showed that nine formal complaints had been received in the year to date. Each complaint had been addressed appropriately and recorded clear actions and follow-up that was required, generally to the satisfaction of the complainant. However, one relative described a complaint they had made about a staff member and that the complaint had been shared with the staff member. They told us, "They told the person who I made the complaint about, which I wasn't happy with". Another relative said they would take their complaint, "Initially to the manager. If I wasn't satisfied, she would give me a form to take it higher". A third relative said they would talk to the manager but that they had never had to make a complaint. The provider's complaints policy stated that formal complaints would be acknowledged within three working days and a formal response would be sent out within 14 working days. There was information about how to appeal, if needed, and the contact details for the Commission.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager since February 2016. The current acting manager was in the process of registering with the Commission and to handover to a new manager who was due to take up their post in September 2016. The head of nursing and quality, the acting manager and deputy manager had shared responsibilities for running the service in the interim. Generally, staff were positive about the support from the management team at Haviland House. One staff member said, "I really like Haviland House, especially on the suite, it feels like a community". Another member of staff referred to management and said, "When they are here, they always check you're okay". However, staff we spoke with felt that staffing overall was an issue. A third member of staff said, "I love working here. Staffing is constantly short. There's lots of agency and more so at the weekend". They added, "We do have some really good staff and we're working with good people. If residents are happy, we're happy. If communication was better [between management and staff], it could be a really good home".

A range of audits had been set up to monitor and measure various aspects of the service provided. In addition, a Continuous Improvement Plan had identified areas that were working well and areas that required improvement. For example, not all staff who had been employed for over two years had received an annual appraisal and there were plans to complete these, with progress made against the action and completion date. Other areas for improvement which had been identified by the provider included the need to involve families in the monthly review of people's care, the development of team leaders and to ensure that staffing levels were consistent, particularly at weekends. Accidents and incidents were analysed monthly and any patterns or trends were identified to mitigate risks and prevent reoccurrence. An audit completed in April 2016 relating to a night inspection of the home by the provider stated, 'Improve environment at Bramber and Clapham – add areas of interest, particularly at end of corridors'. At inspection, we found the end of the corridor in Bramber suite still required attention (see last paragraph under 'Effective'). An observation audit completed in May 2016 in Bramber and Clapham suites recorded that there were some positive interactions between people and staff, but noted, 'Throughout the observation there was minimal discussion or natural conversation between staff and residents'. This was in line with our observations (see end of paragraph 2 under 'Responsive'). The provider had identified areas that required improvement through audits, but, in these instances, had not taken the necessary action identified.

We recommend that the provider ensures that any actions identified through audits include dates when matters of concern need to be completed, to ensure that areas for improvement are addressed in a timely manner.

People and their relatives were involved in developing the service and regular meetings were held to obtain their feedback. We saw notes of 'Family and Friends meetings' held in February, April, June and July 2016. Discussions took place on issues such as staffing, housekeeping, catering and activities. Meetings were convened at 2.30pm or 6.00pm on alternate meetings to offer everyone a chance of attending at a time that suited them. A relative said, "I can come in and I can see the manager anytime I like. I speak to [named staff member] about Mum's care. I get regular emails about friends and family meetings and I've been to one or

two. Communication has never been a problem". Another relative thought the service was well managed, but added, "There isn't a board to say who is on duty".

A survey had been sent out to people living at the home and feedback obtained in October 2015. People were asked whether they felt able to raise concerns, whether their care needs were met, whether they felt comfortable and safe and their views about the staff. Responses to these questions were positive overall. With regard to a question, 'Are you able to access activities of your choice?', one person had replied, 'More trips out, not enough activities'. As a result, a volunteer was organised to take people on outings every week, accompanied by a staff member. In response to a question, 'What do we do well?', one person stated, 'I enjoy the company of carers. They know when to leave me to do my own thing'. People also commented on the high use of agency staff.

A number of compliments had been received and one, dated June 2016, related to the improvement a relative had seen with their family member since they had moved to the home. They stated, 'Within weeks, she was sitting up with good upper body strength and movement, her eyes sparkled … and best of all, she had regained some communication skills'. A member of staff said, "Residents' relatives are really nice and praise you and let you know you're doing a good job. Nice comments and good feedback is really good to hear".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider did not deploy sufficient numbers of staff to ensure people's care and treatment needs were met. Regulation 18(1)