Regal Healthcare Homes (Coventry) Limited

Haven Nursing Home

Inspection report

New Road
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Coventry
West Midlands
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Tel: 02476368100

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 May 2018 and 22 May 2018. The first day of our inspection visit was unannounced. We returned to meet the provider and speak in more detail to the registered manager. Haven Nursing Home is a large nursing home, which is registered to provide care for 70 people, of which 10 beds are part of the 'Discharge to assess' (D2A) scheme (funded by Clinical Commissioning Groups and North Warwickshire Foundation Trust). The D2A scheme aims to ensure people are moved out of hospital (when medically stable) to receive a period of rehabilitation/re-ablement in a community setting, prior to assessment of their long term care needs. At the time of our inspection visit there were 55 people living at the home, 7 of whom were on the D2A scheme.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had a 'registered manager' in post appointed by the provider. 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 June 2017, there was one breach of the legal requirements and Regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to the management of medicines. At this inspection we found there were no breaches in the Regulations, however, we have rated the service as 'Requires Improvement' as the registered manager and provider needed to embed and sustain safe procedures, and demonstrate they were consistently mitigating risks to people's safety.

Improvements were still required to medicines management procedures to ensure people always received their medicines, and the administration of medicines was always recorded. Medical equipment was not always stored in line with safety guidelines.

People felt safe, and personal risks to people had been assessed to inform staff how people should be supported safely. However, risks were not always mitigated, for example where people had specialised equipment to protect their skin, we found this was not always used properly.

The environment at the home required improvement, to ensure it was always safe for people. Equipment needed to be more closely monitored to ensure it was always safe to use.

At this inspection, we found action had been taken to ensure care plans were reviewed and updated regularly so people's needs had been properly assessed and could be met.

There were enough staff to meet people's needs safely, however, there were not always enough staff to meet people's preferences in a timely way. Staff did not always take opportunities to engage with people due to time constraints. Further improvements in the way staff were deployed was being implemented. Staff were recruited safely and were aware of their responsibilities to protect people from harm or abuse.

Staff received essential training to meet people's individual needs, and effectively used their skills, knowledge and experience to support people and develop trusting relationships. Food and fluid intake was monitored where people were at risk, and action was taken where required.

Staff were clear about their responsibilities under the MCA (Mental Capacity Act 2005) and DoLS (Deprivation of Liberty Safeguards) legislation. People's capacity to make decisions had been assessed, and DoLS applications made as required. However, it was not always clear which decisions people needed support to make and who was involved in making the decisions.

People told us they were supported with kindness and respect, and staff respected people's privacy when supporting them with personal care tasks. A range of activities were on offer, and people could maintain hobbies and interests they had.

The provider ensured they received, handled and learnt from complaints and concerns raised by people. People, relatives and staff were positive about the registered manager and the senior team, and felt they were effective and approachable.

Systems designed to check on and improve the quality of the service provided were not always effective, and had not picked up on some of the issues we identified. However, the registered manager and provider were working to improve audits and checks at the home, and were empowering some senior staff to be involved in these procedures. An improvement programme was in place at the home, which included the updating of the environment, décor and an improvement in the quality of care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Procedures around the safe management of medicines needed to be embedded into practice to ensure people always received their medicines, and the administration of medicines was always recorded. Equipment and premises required closer monitoring to ensure the environment was safe for people. Staffing levels required review to ensure people always received care promptly. Staff knew what action to take to safeguard people from the risk of abuse, and the provider had measures in place to ensure they recruited people who were suitable to work in the home. Risks were assessed in line with what was recommended in people's care plans.

Is the service effective?

Good

The service remained Good.

Staff completed induction and training, and were supervised, so they had the skills they needed to meet people's needs. Peoples' nutritional and hydration needs were met. Staff referred people to healthcare professionals when needed and worked closely with healthcare and other professionals. People's rights under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were protected.

Is the service caring?

Good

The service remained Good.

Staff supported people with kindness and respect. People were encouraged to maintain and increase their independence. People made choices about who visited them at the home.

Is the service responsive?

Good

The service was responsive.

People told us staff usually responded to their requests for assistance in a timely way. People knew how and when to complain and felt confident to do so. There was a range of

activities on offer, and people were supported to maintain their hobbies and interests. The provider was developing activities for people who were cared for in their rooms, to offer people individual stimulation. Care records were usually up to date, and described people's care needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and staff described the management team as approachable and responsive, due to the improvements being made at the home. However, systems designed to check the quality of the service were not always effective and required further development. Investment was being made in the home by the provider to redecorate and enhance the environment over a phased improvement plan.

Haven Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 22 May 2018. The inspection visit on the first day was unannounced and was conducted by two inspectors, an expert-by-experience, an assistant inspector, and a specialist advisor. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. A specialist advisor is someone who has current and up to date practice in a specific area, for example, in nursing care. On the second day an inspector visited the home and the visit was announced.

Before our inspection visit, we looked at and reviewed the Provider's Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan. We found the PIR reflected the service provided.

Before our inspection visit we reviewed the information we held about the service. We looked at the feedback we had, from people who used the service, their relatives and staff members. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services and fund the care provided. We also looked at statutory notifications sent to us by the registered manager and provider. A statutory notification is information about important events which the provider is required to send to us by law.

We spoke with nine people who lived at the home and four people's visitors or relatives and observed interactions between people and staff during our inspection visits. We gathered feedback from several members of staff including the registered manager, the clinical lead, an occupational therapist, two nurses, an activities co-ordinator, and three members of care staff. We also spoke with a chef and four visiting health professionals.

Many of the people living at the home were not able to tell us about how they were cared for and supported

because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records to assess whether the care people needed was being provided; including seven care files medicine records and fluid charts to show what drinks people had consumed.

We reviewed records of the checks the registered manager and the provider made to assure themselves people received a quality service. We also looked at recruitment and supervision procedures for members of staff to check safe recruitment was followed and staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in June 2017, when we rated Safe as 'Requires Improvement'. At that inspection we found systems to ensure safe medicines management needed to be improved, sustained and embedded in practice. At this inspection we found improvements had been made and the requirements of the regulations were met. However, we found some improvements were still needed, and procedures and practices needed to be embedded to ensure people always received their medicines when they should. We also found the safety of people required closer monitoring to ensure the building and equipment in use at the home were secure and safely maintained. We have rated the service as 'Requires Improvement' in Safe.

Staff who administered medicines received specialised training in how to administer medicines safely and had regular checks to ensure they remained competent to do so. People told us they received their medicines when they should. One person said, "The nurses stand and watch that you have taken it. If you have a headache they do you give you pain relief."

Medicines such as liquids and tablets were stored safely in line with manufacturers' guidance. However, topical medicines such as creams were not always stored securely. This was because topical medicines were stored in people's bedrooms, to make them accessible to people and care staff. However, this type of storage may pose a risk to people with dementia who may become confused and ingest their medicine. We brought this to the attention of the registered manager; procedures and risk assessments were put in place straight away to safely store topical medicines and other items in people's rooms such as fortified drinks. The provider had policies and procedures in place to ensure people who were able to manage their own medicines, were able to administer their own medicines if they wished.

Records did not always show when staff were applying topical medicines such as creams, although staff told us they were applying them. The registered manager had identified this as an area of improvement, and had put in place application records for the administration of all topical medicines. Some people were prescribed medicinal skin patches. Nurses were following the manufacturer's instructions to safely apply the patches.

The registered manager and clinical lead nurse told us what further improvements were planned around the management of medicines, which records and procedures to direct staff about when to administer some 'as required' medicines. Paperwork was also being reviewed to ensure medicines that required a certain time between doses, such as for pain relief, the actual time they were administered was recorded so that a gap of four hours or more could be checked between doses.

At our last inspection visit we were concerned about the safe storage of oxygen cylinders. At this inspection the registered manager and provider demonstrated oxygen cylinders were stored safely.

People told us they felt safe at the home. One person said, "If I don't feel safe I would try and find the person with the most senior position to speak to." Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns to the registered manager, the clinical lead

nurse or the provider. One staff member told us, "I can go to the nurse or manager and report abuse. I would also go to the provider or CQC if I needed to, but I have never seen anything to report."

The registered manager made safeguarding referrals to the local authority, and worked with other agencies to ensure people were protected from the risk of abuse. Safeguarding concerns were monitored and lessons could be learnt from them. Accidents and incidents were recorded by staff and monitored to show when and where they happened in the home, and whether risks could be mitigated to reduce the number of accidents in the future.

Staff told us and the PIR confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff. All prospective staff members had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. The provider also checked the registration of nurses with their regulatory body to ensure they maintained their professional registration.

People told us they were happy with the cleanliness of their bedrooms and the home. The registered manager told us they were gradually updating furniture and the premises through a re-decoration programme, to improve soft furnishing and make them easier to clean. Restrictions on financial resources meant this was a planned refurbishment taking place over a period of time. In one person's room we saw their bedding and mattress were torn. When we brought this to the attention of the registered manager, they instructed staff at a team meeting to remove any items of bedding that were ripped, torn or stained and dispose of them immediately. They explained staff should have previously disposed of these items, they were working towards the removal of worn bedding as part of the refurbishment programme. Records confirmed this; ten new mattresses and bedding had been delivered to the home to change worn items. One person who lived at the home told us, "My room is clean, they [staff] clean it for me. There's nothing dirty here, the carpets and chairs are cleaned every day. They do the laundry every day and sort it out."

Infection control procedures were in place to prevent the spread of infection. There were regular cleaning schedules, and enough housekeeping staff to keep communal areas and people's rooms clean. However, during our inspection visit we saw an area where clinical waste was stored, but waste was not emptied in a timely way [although the area was not accessible to people]. We brought this to the attention of the registered manager, who explained staff were assigned each shift to empty the waste bins, but this had not been done on the day, as it should have been. On the second day of our inspection visit the area was clean and tidy, with waste being appropriately stored.

We received mixed feedback from people and their relatives about whether there were enough staff at the home. One person said, "Sometimes we have to wait to go to the toilet." They added, "It's just a couple of minutes usually." A comment from one person's relation was, "On the whole there are enough staff, but on occasion they can be short-staffed."

People told us there were not enough staff at all times, to assist them with their personal care when they wished. One person said they were still waiting for help with their personal care needs at 10.40am. Another person said they waited three hours for assistance from night staff. They told us they felt the night staff didn't do enough to make sure they were supported with drinks, their fluid and catheter. They added, "The day staff are marvellous."

Other comments included; "They [staff] are always so busy. I don't think they have enough staff", "I can't always have a shower when I want one, it's 10.25am now and I haven't had one yet". When we reviewed care

records for the assistance people received each day, it was clear staff were busy and did not always have time to provide everyone with personal care before noon, although it was unclear from records about how long people waited for assistance.

During our inspection visit, there were enough staff on duty to keep people safe. However, we were concerned that there were not always enough staff to meet people's individual care preferences and always respond to people in a timely way. We saw one person calling out for staff. Unfortunately the person was unable to use a call bell, and staff had not heard them calling out. Staff told us there were constraints around how the home was laid out, as the home had long corridors and areas where staff could not see people's rooms, or hear them. The registered manager agreed the layout of the home did not help staff identify when people needed assistance. They added a new system, where staff checked on each person regularly, had been introduced to try and respond to this issue.

Since our previous inspection, the provider had already taken action to increase the numbers of permanent staff employed at the home. This was to reduce the number of temporary staff and to support people with a consistent staff team who knew them well. In addition, the registered manager had made some changes to how staff were deployed, staff were assigned to three separate teams, to support different sections of the home. Each of the three teams was overseen by a nurse on duty. This meant people were attended to by staff who knew them, and their routines, well.

The registered manager explained the further measures they were taking, to improve the timeliness of care. They explained the daytime staffing team did not start until 8.00am. As 7.00am until 9.00am was the busiest time of the day, the registered manager was changing the shift patterns of some daytime staff to start work at 7.00am. This would alleviate some of the pressure of the early morning, when people sometimes waited for assistance. Staff members told us the recent changes around staff deployment had improved the responsiveness of staff to people at the home. One staff member said, "Sometimes we were short at weekends, they [the registered manager] have sorted that now." Staff said they now worked in a team to ensure jobs were completed.

We saw staff attended to people quickly in the communal areas of the home, as there was a member of staff assigned to each lounge area to ensure people's safety. A commissioner of services who visited the home told us, "The lounges are always being monitored by at least one member of staff and the interaction between staff and patients [people who lived at the home] is lovely to see."

The provider did not always monitor and mitigate the risks to people at the home, to ensure the premises and equipment were safely and securely maintained. For example, some equipment was not regularly serviced by the provider. In one person's bedroom we saw that the last time their bed had been serviced was in April 2014. There was not a procedure in place for monitoring mattress pumps, to maintain the airflow for specific types of mattresses. For example, two mattress pumps had a service sticker to say they had last been serviced in April 2014. The registered manager told us on the second day of our inspection visit that the provider had employed a contractor to conduct equipment maintenance checks and servicing at the home following our feedback.

Some people's mattresses were not being monitored adequately by nursing staff and through audit checks, to ensure they were set correctly. For example, we found more than one person's mattress was not set at an agreed level. Where people are at risk of developing damage to their skin, they are often prescribed a specialist air flow mattress, to help prevent skin damage. These types of mattresses were in use and the recommended mattress settings for each person was displayed on their bed. Following a safeguarding concern, and our previous inspection, the registered manager had implemented a system show mattress

settings at the end of each bed, staff were instructed to check they were set correctly during personal care routines, and nurses audited these settings every month. However, these systems had not been reviewed adequately to assess their effectiveness.

Following our inspection visit the registered manager told us they would re-brief staff on the importance of mattress setting checks, and improve auditing techniques. However, we could not find any impact on people at the home, due to their mattress being incorrectly set.

In some people's bedrooms we saw their window was wide open, and people could easily climb out, or in, the window. Although the building was only one level this made the building unsecure. In addition, some people assessed as at risk, may leave the building which was situated alongside a main road with unsecured grounds. We brought this to the attention of the registered manager and maintenance contractor on the first day of our inspection visit, on the second day we found windows were secured and locked. The provider and registered manager were reviewing how window restrictors could be fitted to mitigate any risks we had identified.

Some items in people's rooms were left in a poor state of repair. For example, in one room we saw the person's bedrails were broken. In two rooms we saw wires to equipment needed to be changed or covered, to ensure they were safe. The registered manager told us there was a maintenance book, which we later reviewed, where care and nursing staff could record such issues, as they were regularly in people's rooms. The maintenance man was on site daily and could be called upon to fix items that were broken. On the second day of our inspection visit these maintenance issues had been checked and repairs undertaken. Staff had been briefed about the importance of reporting such issues. The registered manager reviewed the audit procedure and maintenance procedure, following our inspection visit, to ensure issues like these were identified in the future.

Recognised risk assessment tools were in place to manage and mitigate personal risks to people's welfare. For example, people had risk assessments in their care records which detailed to staff what risks each person had to their welfare, and how staff could mitigate such risks. For example, what equipment staff needed to transfer people safely. Risk assessments were regularly reviewed to identify any changes in people's needs or abilities. However, we did find two care records where changes needed to be made because their needs had changed. Staff were aware of the changes. By the second day of our inspection visit the records had been altered.

Good

Is the service effective?

Our findings

At our last inspection we rated Effective as 'Good', at this inspection we found staff continued to have regular training and support from their manager, that built their skills and knowledge, and people were supported to access healthcare. We continue to rate Effective as 'Good'.

Most of the people and relatives we spoke with at Haven Nursing Home were complimentary about the skills and knowledge of staff. We saw staff used their training effectively to support people when assisting them to move around the home. Nursing staff used their skills to effectively utilise equipment at the home, such as specialist feeding equipment. However, one person told us they were uncomfortable sometimes when being moved by staff, saying, "When staff assist you (hoist you) I get frightened. I shouldn't but I do."

All staff received an induction when they started work at the home which included working alongside experienced members of staff. Induction courses were tailored to meet the needs of people who lived at the home, and the different roles staff performed. Training records showed new staff were undertaking the Care Certificate which shows staff have reached a certain level of skill. Staff told us their training was then kept up to date so they continued to be competent in their role. Staff were being supported to complete national vocational qualifications in health and social care to improve their knowledge and practice within the home. One nurse told us they had been supported to revalidate their nursing qualification saying, "The manager and a local healthcare professional are helping to keep my skills up to date."

Staff told us they received regular support and advice from their immediate line managers and nurses, which enabled them to do their work. There was an 'on call' telephone number they could call outside office hours to speak with a manager, and there was always a nurse on duty at the home. Regular team meetings and individual meetings between staff and their managers were held. These gave staff an opportunity to discuss their performance and any training requirements. One staff member said, "If I do have any concerns then I will speak to my manager." The registered manager confirmed staff could ask for a meeting at any time.

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).

People told us staff asked their permission before supporting them. Staff understood that sometimes decisions needed to be made in people's 'best interests' and told us they would refer to a senior staff member or a nurse if they were unsure. Staff respected people's right to refuse care and treatment. For example, one person had consistently refused to have some observations undertaken for the last three months, which they had respected as the person had capacity to make this decision.

Care plans showed where people lacked the capacity to make all of their own decisions; a mental capacity assessment had been undertaken. On the first day of our inspection visit we saw the capacity assessment documents did not always show how decisions and assessments were undertaken for people who lacked full capacity. After providing our feedback to the registered manager, we found on the second day of our visit, new paperwork was being introduced which was clearer. Where people were unable to make their own decisions, around managing their finances for example, care records showed who should be involved in making 'best interests' decisions, and who had been consulted about decisions.

Where people had been assessed as lacking and restrictions were in place on their care, the provider had applied to the 'managing authority' for this to be assessed to ensure the person was not deprived of their liberty unlawfully.

People told us they enjoyed the food at Haven. Comments from people included; "The food is very good" and "There is a variety of foods. [Name] loves her food and eats well. She generally always has two puddings." People ate their meals with pleasure. People could choose where to eat their meal, whether this was in the main lounge/diner or in their rooms. People made choices each day about what they wanted to eat from freshly prepared food. For those people who had short term memory loss or dementia, a visual choice of meal was made at the mealtime, so they could see and smell the choices on offer. One person said, "If you want something different they [chef] will get it for you."

The registered manager had employed a new chef in the last few months, who had greatly improved the food on offer at the home. They had introduced fortified meals, snacks and drinks, such as milkshakes and ice creams to encourage people to take extra calories. This helped people to maintain a healthy weight. The chef explained, "For people who need extra calories we use a lot of cream and butter and enrich the food. We also encourage booster milkshakes. I rely on nurses and office to inform me about people's diets."

During lunch people had access to drinks of their choice to accompany their meals. Where people needed support to eat, staff were patient and did not rush them. Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People also had drinks available in their room, although we saw that these were not always in people's reach. During the first day of our inspection visit one person called out for a drink from their room, because they had dropped their beaker and could not reach a drink. In addition one person told us they were thirsty and had not received a drink until 11.00am that morning. However, we did not see anyone who was de-hydrated. The registered manager told us each team of staff were assigned specific times of the day to ensure people had drinks available in their room. This meant drinks were refreshed when people had their meals, snacks, and also when care staff made visits to their room. One relative told us, "There are drinks available throughout the day. They [staff] are always going round with cakes, biscuits and drinks." Nurses told us they also monitored people for the signs of de-hydration during their morning and afternoon rounds. The registered manager told us they would remind staff to fill in records clearly.

Where people needed to have their fluid intake monitored by staff, to ensure they were drinking enough to maintain their health, staff had daily fluid charts in place for people which were filled in whenever people had a drink. People had a target amount of fluid to consume each day, to optimise their health. When we reviewed fluid charts for people we found these were not always fully completed in the afternoon, and did not always show a total amount of fluids people had consumed at the end of each day. We were sure this was a recording issue, the clinical lead nurse told us, night nurses were tasked with totalling the records each day to check the recommended fluid intake was met. If there was an issue with anyone's fluid intake, then this was handed over to the daytime nurse coming on duty at 7.00am the following morning. Action was then taken, people were encouraged to drink, or when necessary a referral was made to a health

professional to seek advice.

Staff told us care records were usually kept up to date. Staff could describe people's individual support needs, as they knew them well. Everyone's needs were assessed when they came to the home, and a temporary care plan was put in place on admission at Haven. This was then developed further as staff's knowledge grew about the person's individual needs and preferences.

Staff and health professionals told us they worked in partnership with each other to meet the needs of people at the home. Care records included a section to record when people were seen or attended visits with healthcare professionals, and their advice. The registered manager and nursing staff described their relationship with visiting health professionals as good. For people who received care under short term care packages, to assess their needs, there was an onsite occupational therapist and a physiotherapist, to offer help and support to encourage people to become more independent and mobile. These health professionals met each week to input into a multi-disciplinary team meeting, held at the home, to discuss the progress and rehabilitation of people.

During our inspection visit we spoke to four visiting health professionals, comments included, "There has been a steady improvement in the home recently, with the registered manager and nursing team they have in place now", "We work together to get the most benefit for people", "The local doctor is working closely with the home to improve outcomes for patients", "There is a clear family and patient focus now."

The registered manager told us the doctor and other health professionals visited the home whenever needed. The doctor also made a weekly round visit to the home, to review people's care needs. One person said, "The optician comes as well just to check your eyes." A member of staff told us how working with other health professionals could increase people's quality and enjoyment in life, by helping them to remain healthy and active. One staff member said, and records confirmed, "We have had people who have come into the home with damage to their skin, and some people are cared for in bed, so we need to monitor their skin closely. We have healed people's skin by being pro-active in treating their wounds and following 'best practice' guidelines."

A health professional who visited the home to check on people's feet told us, "When I visit I find it a warm and caring place. People are always clean which shows that the hygiene levels are of a good standard. Staff are always helpful when I ask for assistance."

The environment at the home was not purposely designed to meet the needs of people who were elderly and frail, and had dementia. There were a range of corridors and rooms, which were not visible to staff from the communal areas of the home that was large and spread out. This made it easy for people with confusion to lose their way. However, where possible the provider had updated the building to increase people's access to certain parts of the home, and to make the environment homely with pictures and new decor. Ramps had been put in place where levels around the home changed, so that areas were easily accessible to people.

Where people were living with dementia, the environment gave them some visual clues and prompts to locate their bedroom and facilities at the home, such as pictures of toilets and bathrooms which made them easily identifiable. The provider planned to improve signs around the home to increase people's awareness of their surroundings; this was part of an on-going re-decoration programme. The registered manager was also looking at ways photographs, colours and pictures could be introduced around the home, to provide people with more personalised clues to find their room.

Good

Is the service caring?

Our findings

At this inspection, we found staff continued to be caring and engage with people at the home. People were encouraged to maintain and develop their independence. We continue to rate Caring as 'Good'.

Most people spoke positively about the caring attitude of the staff, a typical comment was, "They [staff] are kind and helpful." One relative told us about a time staff had gone the 'extra mile' for their relation saying, "When [Name] wasn't well a member of staff was concerned and stayed with them more than an hour over their shift."

We observed good relationships between people and staff when staff had time to spend with people in the communal areas of the home, such as staff sharing jokes with people, telling stories about activities or trips, and chatting about the environment.

One staff member told us how much they liked working in the home, and explained they felt the staff and the provider offered people personalised care that met their needs. They were keen to tell us their relation lived at the home, and they were happy with the care they received.

People's care and support was planned in partnership with them and people who were important to them, which enabled staff to deliver personalised care. Records gave staff information about people's personal preferences for how they wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs and brief information on people's life history so staff could get to know them better. The registered manager had introduced a document called 'This is me' which is a recommended document used by the Alzheimer's Society. The document is designed to describe the needs of the person and their history, so that people with dementia can be cared for in a personalised way. Care reviews took place monthly, or when people's needs changed.

People's ability to communicate with staff and each other was assessed at Haven Nursing Home. We found some people with disabilities used specialist communication tools to assist them. For example, one person used a tablet computer to communicate with their relatives. Other people used visual prompts. However, we also found one person who was asking to wear their glasses, and their glasses were broken. When we raised this with the registered manager it was clear the person was had caused the breakage. However, it was unclear when this incident had occurred from the documents we saw. The registered manager told us following our feedback, the optician was consulted about how more robust frames could be used to prevent future breakages.

Staff promoted people's independence and encouraged them to do things for themselves where possible. For example, people who were recently discharged from hospital were encouraged to work with an onsite occupational therapist and physiotherapist, to improve their mobility and rehabilitation. This was with an aim to discharge people back to their own homes wherever possible.

Some people had personalised items in their room such as photographs of family and friends, pictures on

the walls and ornaments personal to them. There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. This included a number of seating areas and a lounge area. People made choices about who visited them at the home and were supported to maintain links with friends and family. One family member explained staff made them feel welcome by offering them drinks and meals. Another relative told us, "I have been coming for eleven years, to visit my wife every day. The staff encourage me to feel welcome, and they have made me a volunteer, so I can be involved in the day to day activities and running of the home."

People told us and we saw, people's dignity and privacy was respected by staff in the way they worked and offered assistance. However, we saw care records were not held securely, as these were sometimes left outside their room while staff were with them. We brought this to the attention of the registered manager who told us this had been a cultural practice at the home, but they were addressing this. People now had a plastic holder placed in their bedroom to hold their care records. Staff had been encouraged to always store care records in the holder whilst they were supporting people, to ensure they were secure and private. The registered manager explained staff were being asked to change their practice, but that changes like this sometimes took time to be embedded. They said they would remind staff to use the holders.

People were assigned a specific member of staff called a keyworker. Keyworkers were responsible for maintaining a special relationship with each person they supported, ensuring their social and practical needs were met. Keyworkers also helped to maintain accurate care records for people to ensure they reflected people's current needs. We found keyworkers knew people well.

Good

Is the service responsive?

Our findings

At our previous inspection we rated the home 'Requires Improvement' in Responsive because people did not always receive personalised, responsive care. At this inspection we have rated the service as 'Good' in Responsive, as the provider had made a number of improvements to care records and tailoring care to be more individual.

We received mixed feedback from people about whether staff always responded to their requests for assistance, and met their individual preferences, in a timely way. Some people told us staff responded to them promptly. However, one person told us they waited too long for staff to assist them, especially when they were waiting for personal care, or wanted to get up. The registered manager told us they had recently [within the previous month] changed staffing levels and the allocation of staff, which they hoped would meet people's preferences, however, these changes had not yet been evaluated.

Some people told us they made everyday choices about their care. One person said, "I choose when I want to get up in my chair, and get back into bed." Another person commented, "We get a shower regularly if you want one. The nurses shower you or you can shower yourself."

Following recent staff changes, a team leader told explained, "We have our own sections now so I run this section with [name] another team leader so we know about our residents [people who lived at the home] and we know their families. We know how to support them and they feel more comfortable because we know their needs."

One person told us how responsive staff had been to their requests saying, "I love gardening and my greenhouse. The manager is ordering me a greenhouse to put in the courtyard outside my window."

There was an activities co-ordinator employed by the provider seven days per week, to ensure people were offered some activities each day. Group activities and interests were organised in the communal areas of the home, and a schedule of planned events and activities were on display. Comments from people included; "We play bingo on some days. They [staff] had the Elvis impersonator last week", "I have my hair done at the hairdressers weekly" and "We went to the town hall last week, brilliant. It was one of the nurses who took me and we had a game of bingo."

The provider offered people the opportunity to have engagement with therapy animals such as dogs, and a dog was present daily. The home also had a cat and rabbit. One person said, "The local farmer brought in a Shetland pony a few months ago." Recent activities and events that had taken place included a celebration for a royal wedding, cake decorating, watching films, 'pub night' and crafts and games. Another person said, "There is a monthly church service and the Salvation Army visit monthly to spend time with people providing spiritual support."

The activities co-ordinator explained how they supported people who stayed in their rooms. They said, "Every day is different. Today I am doing room visits. That can involve anything. Disco lights, reading, holding

hands. I do that twice a month." We saw people had records of activities they took part in, which also documented when they had room visits. However, for one person room visits were not regularly recorded, and they were cared for in bed. We brought this to the attention of the registered manager who explained some people refused to take part, however, they confirmed, and plans showed, they were introducing more activities for people in their rooms to prevent people from feeling socially isolated. Where people refused activities, they would document this in the records.

Staff told us they were concerned they didn't have enough time to offer people social support and mental stimulation, as they were too busy with care tasks. One staff member told us, "You need to leave everybody clean and feed everybody, but then have you got the time to sit with them?" The registered manager explained they were trying to change the culture within the home, and give staff time to spend with people rather than simply focussing on tasks, by briefing staff on how they could interact with people on a daily basis and make daily tasks more interactive.

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the registered manager if they needed to. Complaints received were investigated and analysed so the provider could learn from them. Most people told us they had never needed to make a complaint, and other people commented that staff responded promptly when things were brought to their attention. One person said, "You go to the manager and she will sort it out for you."

People at the home had been consulted about their wishes at the end of their life when they wished to do so. We reviewed care records which documented their preferences. Nursing staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. Plans showed people's wishes about who they wanted with them at this time and the medical interventions they agreed to.

Some people had documents in place to record when they did not want to be resuscitated following heart failure. W here people had these documents they had been drawn up by medical professionals. We saw that one person's document, prepared by medical professionals, had not been discussed with them or their family. The registered manager told us they would review all such documents with a doctor, and involve the person and their family members in the discussion.

One person's care records, out of the seven we reviewed, were not completely up to date and did not comprehensively instruct staff on how they should support the person. Whilst care plans contained information for staff on how to respond to people's needs, they did not always give sufficient detail for this to happen. For example, one person's care plan advised staff to 'comfort and distract' the person should they become upset or agitated. However, there was no information for staff on how best to do so. The person's records also lacked up to date detail on the type of bed they used. We raised this with the registered manager, who immediately updated the person's records.

Other care records we looked at had been reviewed and updated so information in them was accurate. Care plans in place for people when they were discharged from hospital and admitted into the home, included information about any risks associated with their care, as well as goals that had been identified for the person to work towards while staying at the home. They showed how staff communicated with professionals involved in people's rehabilitation and assessment so the provider could respond as people progressed.

People's main care plan was supplemented by an additional folder in their bedrooms, which included 'at a

glance' information for staff to refer to. The registered manager explained these had been developed to ensure staff had time to read important personal information about people quickly. This idea was being developed further as a laminated display board in people's rooms for staff to access, which was easy to see and clean, and protected people's privacy by having a picture on the side of the document that was on display, rather than people's personal details.

Staff were able to respond to how people were feeling, and to their changing health or care needs because they were kept updated about people's needs at a handover meeting at the start of each shift. The handover meeting provided staff with information about any changes in people's needs since they were last on shift.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the service was not consistently well led. Improvements were needed to ensure people were cared for safely, and the management team were identifying where actions were needed to ensure people always received safe and responsive care. We rated the service as 'requires Improvement' in Well-led. At this inspection we continued to find that people did not consistently receive safe care, and the provider did not always identify where improvements were needed. However, the service had improved in a number of areas since our previous inspection. We continue to rate the service as 'Requires Improvement' in Well-led.

We found the registered manager was responsive to our feedback during our inspection process, and acted straight away to improve things. The registered manager was part of a management team which included a clinical lead/deputy manager, lead nurses who worked at the home seven days per week, team leaders and care staff. Staff told us they felt supported by the registered manager, and since their appointment could see a positive impact on the culture and care provided at the home.
The registered manager completed regular checks on the quality of the service they provided. For example, checks on care records, medicine administration and infection control procedures. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. Action plans were monitored for their completion by the provider during regular weekly quality monitoring visits to the home. This included enhancing and improving the premises at Haven Nursing Home with a re-decoration programme.

At this inspection, we found that, whilst some quality and auditing checks had identified improvements, checks had not identified all of the issues we found at our inspection visits. The registered manager assured us that improvements at the home were a 'work in progress', some systems and procedures still needed to be embedded in practice and improved to ensure all environmental, equipment and safety issues were being identified and recorded. For example, the mattress settings at the home were not consistently monitored to ensure they were always set at the correct level.

Following a safeguarding concern the registered manager had implemented a system show mattress settings at the end of each bed, staff were instructed to check they were set correctly during personal care routines, and nurses audited these settings every month. However, these systems had not been reviewed by the provider or registered manager to assess their effectiveness. Following our inspection visit the registered manager told us they would re-brief staff on the importance of mattress setting checks and update auditing procedures.

There were also constraints to how quickly some identified actions could be made due to financial resources, the layout and use of the environment and building. An improvement plan was in place to address things, over a planned period of time. Actions were prioritised where they might impact on the care people received. The registered manager explained, "Our priority is always to ensure people are safe. We then need to change the environment and culture of the home over time, to ensure we are embedding procedures and practices that benefit people here." We saw some improvements to the environment had

already been made at the home, including a number of new floors to aid people's movement around the home, a re-decoration of corridors and communal areas, improvements to sluice areas and the kitchen. The garden areas had also been improved to include areas where people could smell and feel different textures, to enhance the outside space.

The registered manager explained they had found it difficult to maintain some of the audits and checks themselves, due to time constraints. They had empowered other staff to assist with checking areas at the home, and checking care records and outcomes for people. This included changing some staff roles and involving nurses in some management tasks. The clinical lead nurse and another lead nurse were assigned some hours each week to assist with these checks. The registered manager hoped this would improve auditing checks.

Spot checks had been put in place to assist with the supervision and support of staff. Senior staff now worked at weekends and at night to assist with this process. This also made senior staff more accessible and approachable to care staff.

People and their relatives told us they felt the home was now well-led. One person's relative described how the home had changed over the last year, with the registered manager and nursing team now being permanently in place to make changes. They said, "There has been a succession of managers who came and went, and it was clear the provider needed to make improvements. The new management team are now making real changes."

People and staff told us they would be happy to approach the registered manager with any concerns they might have, and they were confident these would be dealt with quickly. One staff member told us, "The registered manager is approachable and you can go to her with your concerns, they will be acted on." People and their relatives said, "She's very good. If you want her to come up and see you she will", "I could go and see her now if I wanted to, anytime", "The manager is really approachable. She's open for discussion and does her best to give you a positive outcome on things."

Staff told us there had also been some new initiatives to improve communication and share ideas to make life better for the people who lived in the home. One staff member explained, "We get together and have team leader meetings as often as we can and give our ideas." Some staff told us they had helped redecorate some areas of the home because they wanted to make the environment better for the people who lived there and were committed to making the home a success. Another staff member said, "The atmosphere here is lovely. By 2019 we are aiming to have completed our improvement plans."

Staff told us they felt supported by the management team at the home, as they now felt valued. The provider had introduced an employee of the month award who were given a financial bonus of £100.00. Some care staff had recently attended the dementia exhibition at a local exhibition venue to look at new ideas and innovations for good dementia care. Following their attendance they had said they wanted to create a seaside area for people and this was being put in place at the time of our visit.

The provider and registered manager had reviewed how medicines were managed at the home, and had made improvements to how medicines were ordered and stocked, to ensure waste was reduced. The registered manager was liaising with the local clinical commissioning group as part of a pilot project, to see where further improvements could be made.

The registered manager and staff also worked in partnership with other care homes and experts in their field, to help develop and improve systems at Haven Nursing Home. For example, a nurse and the registered

manager told us about visiting an 'Outstanding' home nearby to learn more about good dementia care.

The registered manager and clinical lead nurse were working with other professionals in their local community, to increase their knowledge and the knowledge of staff. For example, the local clinical commissioning group supported staff at Haven with training sessions and training materials, the local doctor assisted nurses to maintain their skills, and was supporting one nurse to take a higher level qualification.

People could give feedback about their wishes. The registered manager had previously organised a meeting for 'residents' and relatives, however, they told us attendance was poor. They planned to continue to engage relatives and people in feedback about the home using coffee mornings, yearly quality assurance surveys and gathering comments from people in the reception area and in care review meetings.

To encourage care records and care plans to be more responsive to individual needs, and to identify premises and equipment issues more readily, they had also introduced a scheme where each day one or more people were visited by the activities co-ordinator, the chef, nursing staff, maintenance and housekeeping staff, to review their care and preferences.

The registered manager and nursing team worked together to improve systems and procedures for people. For example, they had recently developed a system whereby key pieces of information about the person's health was shared with the local doctor, if the person required a doctor's visit. This new information sharing document clearly described symptoms, proposed interventions to get a faster response, assessment and recommendations to improve people's health.

The registered manager understood their responsibilities under the regulations and notified us of incidents as required. They also displayed the current rating in a prominent position at the home.