Regal Healthcare Homes (Coventry) Limited

Haven Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 18 March 2015. It was unannounced.

Haven Nursing Home provides nursing care for up to 70 older people and people living with dementia. At the time of our inspection there were 61 people living at the home.

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

The registered manager and staff had limited understanding of the Mental Capacity Act and Deprivation of Liberty safeguards. They had undertaken recent training in this, but they acknowledged they needed further advice and support. The manager had not sent applications to the supervisory body (the local authority) for some people who lived in the home whose freedom had been restricted.

Most medicines were managed safely. However information to support staff with the administration of 'as required' medicines was very limited and some of the recording did not meet good practice guidance.

Summary of findings

People and their relatives told us people were safe. They were supported by a staff team who had undergone recruitment checks by the registered manager to check staff's suitability to work in the home. Staff understood safeguarding policies and procedures, and worked with people's individual risk assessments to ensure they minimised the identified risks.

Staff had received, or were booked on training considered essential to meet people's health and safety needs. Staff had received dementia awareness training and training to help them understand and work with people with behaviours that challenged others. But the provider did not have links with specialist dementia organisations to provide more specialist advice and knowledge.

People were supported to have enough to eat and drink and enjoyed the food provided. The provider ensured people's dietary needs were catered for. People who were not drinking or eating sufficiently to stay healthy, were referred to the right health care professionals for further guidance.

People had access to other health and social care professionals when required. These included their GP, dentist, social workers and dieticians.

Staff were caring to people who lived at Haven Nursing Home. They had a good understanding of people's past histories, likes, dislikes and preferences. People told us staff treated them with dignity and respect.

Visitors were welcome at any time during the day and evening at the home, and were encouraged to be involved in the care of their relations. We saw some activities were available to people who lived at Haven, but a lot of the time there was little to sustain people's interests. The manager told us they were recruiting another activity worker which would mean the home had 40 hours of activity work each week.

The registered manager had worked at the home for six months. During their time as manager they had recruited new staff and instigated changes to make it easier for people and their relatives to discuss issues or concerns on an individual or group basis. Not all quality checks had been carried out and this had resulted in some issues not being addressed.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Medicines were not always managed safely. People who lived at the home felt safe, and staff had a good understanding of how to safeguard people and minimise any risks relating to their care. There were sufficient staff on duty to meet people's personal care needs and recruitment procedures protected people from unsafe staff.

Requires Improvement

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

Staff and the manager had limited understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and some people who lived at the home may have been deprived of their liberty without the appropriate authorisation. Staff had the skills, knowledge and experience to provide effective personal care and nursing care. People were supported to eat and drink sufficient food and fluids to keep them healthy, and they had good access to different health care services.

Requires Improvement

Is the service caring?
The service was caring.

Staff had developed positive relationships with people, and treated them with kindness. People were supported to make choices in how they lived their day to day lives. Staff supported people's right to privacy and demonstrated respect in the way they carried out their nursing and personal care tasks.

Good

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

Staff had a good understanding of many people's past histories, preferences, likes and dislikes and used this information when communicating with people. However knowledge of people's past histories was not used to plan individual or group activities although this was being addressed. The new manager had made arrangements to meet with people and their relatives to listen and learn from their experiences, concerns and complaints.

Requires Improvement

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

The people and staff had experienced management changes and the new registered manager had been working at the home since October 2014. The registered manager had made improvements to the service but there were areas which still required development. Staff and people felt the manager was open and accessible to them.

Requires Improvement

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 18 March 2015 and was unannounced.

Two inspectors and a specialist nurse advisor conducted the inspection.

We looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare. We also contacted the local authority commissioners, and two health and social care professionals to find out their views of the service provided. They had no concerns about the service.

During our inspection we observed how staff interacted with people who lived in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two people who used the service and seven relatives. We also spoke with the registered manager, 10 staff (this included nurses, care workers, the activity worker, and kitchen staff), observed the care provided to people and reviewed five care records and seven daily care records. We also reviewed records to demonstrate the provider monitored the quality of service (quality assurance audits), medicine management, two staff recruitment records, and complaints, incident and accident records.

Requires Improvement

Is the service safe?

Our findings

We looked at the administration and management of medicines to see whether people received them safely. One relative, whose relation had 'as required' medicines told us, "I don't think the administration of medicines is safe. I have had to intervene and get involved with my relative's medicines because mistakes have been made that resulted in my relative becoming unwell." The manager was not aware of these concerns but told us they would speak with the relative and ensure the person was administered their medicines safely.

We saw very limited written information about medicines which should be taken 'as required' (PRN). For example, the information for one 'as required' medicine told us the person should be administered this medicines for 'aggressive behaviour'. There was nothing to inform staff about the type of aggression, how the person behaved, and the strategies to use before resorting to administering medicines. Another person was prescribed an 'as required' medicine for epilepsy. There was no information on the medicine record to tell us this, or when the medicine should be administered. The deputy nurse manager checked other 'as required' records and agreed many did not contain the required information. They told us it was on their 'to do' list to check these records but had only been working at the home for three days.

We saw other poor medicine recording practice. For example, a medicine record had been hand written instead of using pharmacy printed details. The record showed some entries had been crossed out and changed without initials of the member of staff or explanation for the changes. The hand written prescription had not been signed either by the nurse who wrote it, or countersigned by another member of staff to confirm the medicine regime had been handwritten correctly. We observed a nurse administering medicines. We saw they were signing the MAR before the person had taken the medicine. This meant if the person had refused their medicine the MAR would be inaccurate and require changing.

Checks on nurse competency regarding medicine management had recently been introduced. However, of the four nurses who had started the assessment process, only one had completed the three assessments required.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw systems to ensure medicines were received into the home in good time to check they were correct and could be given as prescribed; there were also good systems to dispose of unwanted medicines. Medicine Administration Records (MAR) showed people had received their daily medicines as prescribed.

People and their relatives told us they felt safe in the home. One person when asked if they felt safe living at Haven Nursing Home told us, "Yes, Of course I do!" A relative said in response to the same question, "I spend time here every day so I see how the staff care for my relative. I am able to go home and not worry, safe in the knowledge that my relative will be cared for properly."

Staff we spoke with understood the policy and procedure for safeguarding people. One member of staff told us, "I would always report anything I believed to be abuse to the manager. If I suspected that senior members of staff, such as the manager, were doing wrong, I would go to social services and the CQC." We saw the telephone number for the social services safeguarding team was visible and accessible in the manager's office.

We found where people living at Haven had been involved in incidents with other people living at the home; these incidents had been referred to the safeguarding team. However not all of these incidents had been reported to us. The registered manager was not aware of this oversight, as she had delegated this role to other staff, and told us they would ensure the CQC would be notified of these incidents in the future.

The home had a 'challenging behaviour unit'. We spoke with staff about support given to people who had behaviour that could challenge others. Staff explained they sometimes took people's arms and led them away from situations that could result in harm to themselves or other people. We observed two people had bruising to their arms and wrists and we asked staff to tell us how this had happened. They told us some people would grab at others' hands and this could sometimes result in bruising. We found some staff had recently received training in breakaway techniques to remove themselves from harm,

Requires Improvement

Is the service safe?

but none had received training to support them in knowing how to intervene in situations safely and remove people from harm. Staff told us the breakaway training was new to them and they felt their training had improved their knowledge.

Staff we spoke with had a good knowledge of the risks people had and assessed and identified risks in relation to their care. For example, the risks of falling, eating, skin breakdown, moving, and incontinence had been assessed and care plans put in place to minimise the risks to people. One care worker told us, "We have risk assessments in the care plans and they tell us what to do to keep people safe. If you are in doubt, you can always ask another member of staff ."

There were 61 people who lived at the home, none of whom had pressure ulcers. We saw effective skin assessments and strategies in place to minimize the risks of people's skin breaking down and pressure ulcer development. This included regular positional changes and pressure relieving equipment which we saw staff ensured people used throughout the day.

The provider staffed the home based on occupancy of the rooms, not on the assessed level of need of each person. During our visit we saw sufficient staff to keep people safe. However, relatives and people told us that staff did not always have time to sit and talk to them, with one person saying, "Their time is totally committed, and there is no spare slack in the system." They also told us recently there had been a heavy reliance on agency staff. The registered manager confirmed this had been the case but told us they had recruited new staff and the use of agency staff was now minimal.

During the day we saw staff kept people safe by being in attendance at all times within the communal areas so people were not left unsupervised. We observed staff call on, and wait for other staff to relieve them when they needed to leave the communal area. We heard nurse call alarms sound during the day and they were responded to promptly. Where people were not able to use a call bell, the registered manager had put notices on their doors to remind staff to make regular checks to ensure the person was safe.

Requires Improvement

Is the service effective?

Our findings

The manager and staff had recently received training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), however they did not have a clear understanding of the Act in relation to DoLS. We looked at the applications that had been made by the provider to the local authority for authorisation to restrict people's freedom. We found applications had not been made for all of the people who lived in Haven Nursing Home who needed them. For example, there were people who lived at the home who lacked mental capacity to consent, who were not free to leave the home and who were subject to continuous supervision. This meant people's freedoms were restricted without legal authorisation by the local authority.

We found staff had restrained some people by holding down their arms when they exhibited behaviours which challenged. We did not see information telling us this decision had been made in the person's best interest and was the least restrictive option.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had a medical diagnosis which meant their mental capacity might be impaired, there were no written assessments to determine the person's level of capacity and what life decisions they could or could not consent to. Whilst it is not a requirement to record the assessment of a person's capacity to consent or agree to the care planning process, the MCA Code of Practice says it is good practice to record the findings in care plan documentation.

We looked at how effectively staff cared for people. One relative we spoke with told us, "I think the staff know my relative really well. They know what they need and how to support them." Care and nursing staff told us they received induction training and shadowed other staff before they started working on their own. We saw records which demonstrated staff had either received, or had been booked to have training in all aspects of health and social care considered essential to meet people's needs. For example, staff had received training in moving people safely and skin care. We saw staff made effective use of this training. Staff used the hoists and slings safely and re-assured people during the transfer from their wheelchair to armchair.

Nursing staff had been provided with additional training such as syringe driver management training (for the relief of pain during palliative care). Checks on nurse competency regarding medicine management had recently been introduced.

We found that for some people, a record of a Do Not Attempt Cardio Pulmonary Resuscitation orders (DNACPR),were in care files. However, through discussion with relatives and through looking at the care record we found one person had expressed a wish not to be resuscitated but a form had not been completed. Staff had not acted on this information and put a DNACPR in place for the person during a period when the person had capacity to make this informed decision. The family of the person also told us the person would not wish to be resuscitated and they had discussed this with staff. This meant the person could potentially be subjected to unwanted resuscitation by nursing staff or paramedics. We discussed this with the manager who told us they would make sure this was dealt with as a priority.

On the whole, people were positive about the food they received. Comments included, "The food is very good." One person told us they weren't happy with the food because, "It was always swimming in gravy". Food was either served hot directly from the kitchen to people in the main dining area, or plated and covered to take to the other dining areas. Meals were nicely presented and there were good quantities available. For those having their meals in bed, food was plated and covered to keep their meals hot, it was then taken by staff to people's rooms for them to eat. Drinks were provided to people throughout the day.

Kitchen staff had a good understanding of people's dietary needs. We saw special provision for people with diabetes and for people who required their food pureed or mashed to make it softer. Pureed foods were served separately to enable people to distinguish the colours and flavours of their meal.

Where people needed assistance to eat their meals, staff sat by them and supported them to eat with patience and when necessary, encouragement. People who had risks associated with eating and drinking, had their food and

Requires Improvement

Is the service effective?

drink intake monitored. Staff completed food and fluid charts for people who could not tell them whether they were hungry or thirsty to ensure they received sufficient food and hydration. Where there were concerns about people receiving sufficient nutrition, we saw they had been referred to the dietician. One relative, whose relation could not communicate, said, "The food is very good, [person's] likes and dislikes are pinned up. [Person] can't drink coffee. When I'm here [person] has 600mls to drink. I tell the staff and they write it down." We saw staff completed fluid charts and the amounts on the charts suggested people received sufficient fluids. However the charts did not show the totals to aim for, and so staff would not know by looking at the chart whether the person had received enough fluid.

We spoke with a dietician who regularly worked with people living at Haven Nursing Home to ensure their dietary needs were met. They told us staff had a good knowledge of people and referred people to them at the right time if there were concerns about their food or fluid intake. They told us the staff acted on the advice and guidance given.

We looked at people's access to health and social care professionals. One relative we spoke with told us, "My relative has regular check-ups from the GP, dentist and optician. My relative has appointments at hospital and the staff support my relative to attend these appointments." Another relative told us, "They will tell you what's going on, If [person] needs to see the doctor, they will get the doctor in." Care records seen demonstrated that people had access when necessary to health care professionals such as the GP, chiropodist, dieticians and speech and language therapists.

Good

Is the service caring?

Our findings

We asked people and their relatives whether they felt staff were caring. One person told us, “Staff are quite good, if I get into any trouble they come.” Another person told us, “It is very pleasant here at times”. Relatives told us, “Staff are very caring, they are always nice and cheerful when talking to [person]”.

The home is split into three units. An inspector observed staff interaction with people in the communal areas of each unit. We saw interactions between staff and people were warm and professional, and where required, staff were gentle with people.

Staff we spoke with had a good knowledge of people and their life histories. We saw that people and their relatives had been asked to help staff understand the person by documenting their past history, their likes and dislikes, relationships and preferences. Within the document people completed was a ‘life map’ which gave an at a glance view of the family trees and relationships, making it easy for staff to quickly find out the person’s history.

Staff showed concern for people’s well-being in a caring and meaningful way. We saw a person return from hospital. We observed a member of staff become really happy when they saw the person had returned. We also saw, after an interaction between a person and a care worker, the person said to the care worker, “I love you”.

Care workers told us they saw people who lived in the home as family members. One care worker told us, “In my mind, when I have a day off I still think of them (people). I love these people, we are one family.” Another care worker told us, “I’d treat these people like my own grandmother, they’re like family.” This was confirmed by a relative who said, “The staff are very kind and caring. I have no worries about that. They treat people as if they are their own family, they really care.”

We found people had choices in their daily lives. Care records detailed the likes, dislikes and choices people had, and we saw on the day of our inspection people being offered choices. For example, when we arrived at 9am not many people were having breakfast in the dining room. Some were having their breakfast in bed, and some were still asleep. Breakfasts were served between 7.30am and 11am to give people choice when to have their breakfast.

A health and social care professional told us they were pleased with the care provided to two of the people they had professional involvement with. They told us one person had culturally diverse needs and the staff had supported the person well to meet their needs. They also had professional involvement with a person who had behaviour which challenged other people. The professional told us staff provided good care to the person.

We observed staff gave people privacy when they received personal care and treated them with respect. Staff told us they ensured privacy when providing personal care by shutting doors and curtains. They also told us they would knock on people’s doors and wait for them to answer before going into a person’s room. We saw staff respected people’s dignity when lifted using a hoist, when a blanket was put over the ladies skirts to cover their legs.

There were no restrictions in visiting times for friends and relatives to visit the home. One person told us, “I come every day in the morning and stop till 3pm.” Some visitors came at mealtimes to support their relation eating. We saw people were visited in the early morning through to the evening. The provider promoted an open culture for people to visit at any time during the day or evening.

Requires Improvement

Is the service responsive?

Our findings

A relative told us about their relation, "Mum has been here for five years, we are generally very happy." They told us there relation was over 100 years old and had just had a birthday. They said staff sent her a card and made her a cake.

Care records were personalised and gave guidance to staff on how people could achieve their care goals. We saw, with the support of families, some care records had mapped out the person's life story and their past and present interests to help staff respond to people's social and emotional needs.

We saw people with sensory needs who needed to wear glasses or hearing aids were wearing them, and the glasses looked clean. We heard call bells responded to quickly. One person told us, "If I get into any trouble they (staff) come." However, another person told us that staff did not always come when needed.

We did not see where people could be involved in their care, that staff had spoken with people about the care provided, although relatives told us staff had involved them when changes to the person's needs had been identified. The registered manager told us they were introducing a 'resident of the day' system which meant one day each month, the person would have their care needs reviewed and would, where possible, be included in the review.

We saw people looked clean and were wearing clean clothes, however one person who was cared for in bed told us at 11.25am they were not happy because they had been awake for a long time and were still to have their morning wash. We looked at their personal hygiene record which confirmed they had not yet been washed. We looked at another three personal hygiene records. We saw staff recorded whether people had their morning wash and mouth care but there was nothing on the record to indicate whether people had received a wash or mouth care later in the day. We were told people had a shower or a bath once a week. We looked at the record of a person who would not be able to confirm to us when they last had a bath or shower, and the last record showed this had been 10 days previously. Another person's record also suggested they had not had a bath or shower for over a week. When staff saw this, one member of staff said to us, "That's disgusting." Staff could not confirm when the two people last had a shower or bath. When people cannot speak for themselves, accurate records are important because they tell us whether personal care needs have been carried out. These records had not been checked by management for some time.

On the day of our visit we saw limited engagement with activities. In one of the units a volunteer was playing table games with people who were interested, and we saw some people read newspapers. Staff did not have much time to sit and talk with people as they were busy responding to people's personal care needs. Mostly, we saw people sitting in the communal lounges where the TV was playing programmes people appeared disinterested in.

The provider had recently employed an activity co-ordinator who had scheduled group activities for people at different times during the week. These activities were advertised on notice boards in the home and the activity co-ordinator and staff informed people when activities were taking place. The person worked 20 hours, and this had been recognised as insufficient to support the number of people in the home. On the day of our visit the registered manager was interviewing for another activity co-ordinator which would add another 20 hours of activity time. We saw people's birthdays were celebrated, and other celebrations included a Valentine's day buffet.

The registered manager had been working at the home since October 2014. They had introduced a 'relatives' board which informed relatives of when they were available should relatives wish to discuss any concerns with them. The manager informed us they had an 'open door policy'. They also told us they did three 'walk-abouts' each day to check whether people's needs were being responded to, and to talk with any people or relatives who wanted to speak with them.

There were mixed views about the responsiveness of management to concerns. One relative told us, "We have no real complaints as the care here has been really good." Another told us, "We've had some issues as you'd expect, but we told the staff and they sorted it out straight away and the manager came to us to apologise." However, another relative said, "I feel that [manager] isn't really listening to what you are saying, and told us they had approached the manager about staffing in the communal

Requires Improvement

Is the service responsive?

areas. Another told us they had previously been unhappy with management response to their concerns but told us, "The new manager seems to be responding but I can't pile everything on them in one go".

One formal complaint had been received since the new manager started working at Haven Nursing Home. We saw the complaint had been investigated in line with the provider's policy and procedure.

Is the service well-led?

Our findings

The home had recently been through a challenging period of time. There had been changes to leadership with the previous manager leaving, and the position of deputy manager had been vacant for a few months. A number of staff had also left and the new registered manager had been recruiting new staff since her arrival. This meant during the last few months agency staff had been used to ensure there were sufficient staff on duty. On the day of our visit, we found the post of deputy manager had been filled. The nurse who had been recruited to the role had been in post for three days. The manager had also managed to fill most of the staff vacancies.

The current manager had started working at Haven Nursing Home in October 2014 and had recently been registered with us. They acknowledged to us there had been a lot for them to do and learn since they took on the responsibility of manager. They told us they were a 'hands on' manager and worked with staff providing personal care one day each week. They felt this gave them an informal opportunity to support staff in improving staff skills and knowledge and to make them more accessible to staff. The registered manager told us they were 'passionate' about providing good care, and they intended to work at the home for a long time. Staff agreed with the manager's assessment of her management style. They told us they felt able to speak with the manager. One care worker told us, "If I needed any help I would be happy to tell her (manager), she's open."

We spoke with the local authority contracts unit who told us there had been improvements in the service since the new manager started work. A visiting health care professional also informed us there had been improvements in the support given to people's dietary needs since the new manager arrived.

Staff told us they had not recently had formal supervision but the manager showed us a comprehensive supervision programme they had developed and were about to introduce. We saw team meetings were held regularly where achievements and required improvements were discussed.

The registered manager had introduced an 'employee of the month' scheme to celebrate the achievements of staff. Staff received a certificate and a bonus payment if they were identified as such. We found in the last month, the whole staff group shared the bonus payment because the manager felt they had all worked hard to eradicate an infectionutbreak in the home.

Accidents and incidents were recorded and investigated. We saw there had been five incidents in January 2015 which, whilst being responded to appropriately, were not notified to us at the CQC. The manager had delegated this task and was not aware we had not received the notifications. They said they would make sure this was rectified. We looked to see if there were any trends in the accidents reported. There were no trends noted, but the manager said they checked to see if any trends or patterns emerged.

The manager had introduced monthly newsletters and 'resident' meetings. We saw the recent newsletters had requested volunteers to be companions for people living at the home, and to support people with individual interests and activities. The notes of the last meeting were posted on one of the notice boards. They did not include actions the manager would take in response to the discussions held at the meeting.

Because the manager and her team had been working on improving other aspects of the service, we saw some of the quality checks had not been carried out. For example, medicine administration audits and staff competency checks in medicines had not been completed. Similarly checks on daily care records had not been undertaken for some time and we found inconsistencies in these.

The manager acknowledged their understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) was insufficient to ensure they met the requirements of the Act. They told us this would be a priority for them to seek further training and guidance.

The provider and registered manager did not have any links with specialist dementia care providers or advisors to provide them with knowledge and support in the provision of dementia care. There was no member of staff in the home who had specialist knowledge of dementia and this meant the home was providing a specialist service to people with dementia with a staff group who had only received dementia awareness training. The registered

Is the service well-led?

manager told us they would be looking into how they could use the knowledge and skills of external dementia specialists to improve the provision of care for people living with dementia in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who used the service were not protected because of the lack of information provided to staff to safely administer 'as required medicines'.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not met. Some people who lived at Haven Nursing Home had their freedom of movement restricted without a Deprivation of Liberty safeguard application or authorisation.