Guild Care

# Haviland House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Haviland House is a residential care home providing personal and nursing care to 39 people living with dementia and other health conditions at the time of the inspection. The service can support up to 67 people.

People's experience of using this service and what we found
Some people's risks had not always been fully assessed or information and guidance provided to staff on their specific health conditions.

People were supported by kind and caring staff, but we observed occasions when staff were task orientated, so care was not always centred upon the person, or delivered in a way that met their needs and preferences.

Medicines were managed safely. Staff were trained to recognise the signs of potential abuse and knew what action to take. Staffing levels were sufficient to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

A manager had been newly appointed to the service and was in the process of registering with the Commission. The service had identified areas that needed to be improved as a result of their auditing systems, and had an action plan in place to address the issues.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (report published 24 December 2020).

Why we inspected
This inspection was prompted in part due to concerns we had received about the service with regard to the management of medicines, risk management and mitigation, and managerial oversight of the home. A decision was made for us to inspect and examine those risks. We also received concerns about one person who was living at the home. The information that was shared with us is the subject of a specific incident which is being investigated separately. As a result, this inspection did not examine the circumstances of the incident.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well Led sections of this full report. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report. We discussed the issues that were of concern during the inspection, and the provider has taken steps to address these.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Haviland House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to safe care and treatment and a breach in relation to person-centred care at this inspection.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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 always safe.

Details are in our safe findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

# Haviland House

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by two inspectors and a specialist nurse.

Service and service type
Haviland House is a 'care home'. 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 service did not have a manager registered with the Care Quality Commission. A new manager had been appointed and was in the process of applying to be registered. When they are registered, this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service which included concerns raised. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers

to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the director of care homes, the director of nursing, the manager, the head of health and safety, a registered nurse, six care staff and a visiting healthcare professional.

We reviewed a range of records including seven care plans and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training and safeguarding referrals. The provider also sent us a copy of their recovery plan which included areas they had identified for improvement and actions to be taken.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The inspection was prompted in part due to concerns we had received about people's risks not being mitigated or managed safely. Some people's risks were not always identified and assessed accurately to prevent them from harm.
- Two people had a particular health condition which could be managed if they were encouraged with a high-fibre diet. However, the care plans for these people suggested they should be encouraged to eat white pasta and white bread, with low fibre cereals. The low fibre diet recommended within the care plans had the potential to exacerbate the health condition and could have resulted in people becoming unwell with an upset stomach or constipation. Daily records for three days in May showed one person had been given low-fibre foods.
- One person's care plan stated they had a diagnosis of Parkinson's disease and required their medicines to be administered at exactly the right time every day. Although the handover sheet given to staff recorded the times when this medicine should be administered, the person's care plan did not. Lack of information and guidance within a medication care plan meant that staff may not have understood how a delay in administering medicines might impact on the person's wellbeing.
- Another person who lived with diabetes had no medication or diabetes care plan in place, so there was a lack of guidance for staff on how to support this person if they became unwell. However, records showed this person's blood sugar levels were being monitored as requested by the GP.

The provider had failed to ensure the risks to the health and safety of people were always assessed accurately and mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed these issues with the management team. After the inspection we were sent copies of the relevant parts of the risk assessments and care plans that had been reviewed and corrected.
- Other risk assessments had been completed accurately for moving and handling, skin integrity, and falls, for example.

Using medicines safely

- The inspection was prompted in part due to a significant number of medication errors that had occurred within the last 12 months at the home. These had been the subject of ongoing investigation by the local authority safeguarding team.
- At inspection, we found medicines were managed safely. The provider had recently changed the way medicines were managed to an electronic system. The provider considered that changing the system would

result in less errors from occurring, such as people missing their medicines, because the electronic system displayed prompts to staff. However, some senior staff were not clear on medication error management. They told us they would advise the nurse on duty and be given instructions. This is an area in need of improvement.

● The provider had undertaken a mock inspection where various shortfalls had been identified in medicines management and where actions had been identified as needed. Actions had been taken and improvements were made as a result.

● Medicines to be taken as needed (PRN) were managed in line with best guidance protocols. Homely remedies had been signed off by people's GPs and were managed safely.

● People received their medicines from staff who had been trained, and regular assessments ensured they remained competent to administer medicines.

● We observed staff administering medicines to people at lunchtime. Staff waited patiently with people while they took their medicines.

● Where people received medicines covertly, that is without their knowledge, best interests decisions had been taken and were recorded appropriately.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● We were not fully assured that good hygiene practices were followed by staff. We observed people having their lunch in one part of the home. A staff member in the dining room did not practice good hygiene habits. We saw this staff member serving food onto plates from a heated trolley, then handing these to people. They put their arm around one person's shoulders and had a chat with them. A few minutes later we saw them put the dirty plate and cutlery into the dishwasher, and rinsed one hand briefly under the tap. A paper towel was disposed of in a bin which they touched to operate the flip-top lid. The staff member then went back to the food trolley and started to serve desserts onto plates. At no time during this observation did the staff member wash their hands effectively or use alcohol gel or wipes to sanitise them. We fed this back to the management team at inspection, who assured us they would follow this up.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Any incidents were recorded by staff and, where needed, referrals were made to the local safeguarding authority.

● The manager demonstrated their understanding of abuse and explained, "It's any serious injury that has been caused by the running of the service, if it involves a staff member or if the police were involved. For example any medication errors would be a form of abuse and we would notify CQC and the local authority".

● The manager told us that safeguarding training was mandatory and staff would complete this annually. However, not all staff had updated this training as required. One staff member said they had completed the training as part of their induction, but had not updated it since. This is an area in need of improvement.

● Staff we spoke with had a reasonable understanding of what constituted abuse and the action they would take. One staff member said, "We report anything that's not acceptable. We make sure people are well cared for and their wellbeing. We do have some people who display challenging behaviour. It's how we deal with it and the approach you take with people". Staff said they would report any potential abuse to their line manager with an expectation they would take the appropriate action.

Staffing and recruitment

● Staffing levels were sufficient to meet people's needs.

● We observed staff attended promptly to people when they needed help and support.

● Staff confirmed there were enough staff on duty. One staff member said, "There's normally three or four people on each household [unit] in the mornings. Everyone is up, dressed and has breakfast when they want". Another staff member told us there were enough staff, but that it could become very busy if people wanted to get ready for bed at the same time.

● Agency staff were occasionally used to cover gaps in shifts. Staff were dedicated to working at Haviland House and the management team told us they would often block book agency staff to provide consistency of care.

● Where people were unable to use their call bells to summon help, staff undertook regular checks to ensure their wellbeing. Sensor mats were used to monitor some people's movements, for example, when they got out of bed. The use of these had been assessed and decisions made in people's best interests.

● New staff were recruited safely. We looked at recruitment records for two staff. Disclosure and Barring Checks, which related to a person's good character and whether there was any criminal record, had been completed. Potential staff had their employment histories verified and two references were obtained.

Learning lessons when things go wrong

● Lessons were learned when things went wrong

● Where medication errors had occurred, staff had completed reflective practice statements to understand what had gone wrong and how similar incidents could be prevented.

● Where appropriate, staff had undergone additional training and some staff had requested training to augment their learning; this had been provided.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive personalised care that met their needs and preferences.
- We observed staff supporting people around the home. During lunchtime, one person was given their lunch and assisted with their meal by a staff member. There was little communication between the staff member and the person. The person ate a few mouthfuls, then declined to eat more. The staff member then called out across the room that the person had not eaten all their meal, and the other staff member replied that this was because they had eaten lots of porridge that morning. The person did not appear to be happy at being assisted with their meal and staff were disrespectful in the way talked about them. Their care plan stated that staff were to prompt the person to eat, and there was no plan that required the person to be assisted. We later observed the person was offered a sandwich, which they ate independently.
- In another part of the home, we observed staff serving people their lunchtime meal. One person complained to a staff member that their meal was cold and their lunch the day before had also been cold. The staff member then asked the person if they wanted another meal; there was no apology or reassurance provided to the person that they would address their concerns.
- Another person had sat down to eat their lunch, then changed their mind, and left the dining room. Their hot meal was placed on a tray, with a drink, and left on a side-counter. Ten minutes later, a staff member picked up the tray to take the meal to this person's room, so they could eat their lunch there. The meal must have been cold by the time the person received it.
- People were supported by kind and caring staff, although on occasion, staff were observed to be task-led, rather than orientated to providing person-centred care. The home provided a variety of objects and items that people could look at. For example, books, pictures, and items that provided texture or produced sounds that people could touch and engage with.
- At lunchtime, on each table, there was a china teapot and sugar bowl, but both were empty, so served no useful purpose. We did not observe staff supporting people to engage with their surroundings or various props to explore their feelings and emotions, or to prompt conversations. After lunch in one unit [household], we saw people were sat in their armchairs, with little conversation or interactions with staff.

The provider had failed to ensure people received appropriate, personalised care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans provided detailed information about people and included advice for staff on how to support them. For example, one person's care plan stated they could display behaviours that challenged. The care plan included techniques for staff to follow to minimise these behaviours.

● Another person's care plan included information about how they liked to socialise and family members who were important to them.
● A third person's care plan described how they could become confused, upset and agitated on occasion. This person came to talk with a member of the team during the inspection and started to shout at a member of staff who had come to assist them. The staff member tried hard to calm the person, and displayed a caring and compassionate approach, but the person became more upset. The staff member then moved away and the person appeared calmer when they were left alone.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff communicated with people in a way they could understand. For example, one person was slightly deaf and struggled to understand what staff were saying as they wore masks. Staff spoke quite loudly and checked the person had heard what they were trying to communicate.
● People at the home were living with dementia. We saw one person continually tried to pull down a staff member's mask when they were speaking. The staff member patiently explained to the person why they needed to wear a mask and politely asked the person not to pull their mask away from their face.
● Meals at the home were provided by an external contractor. The management team told us there were plans to draw up pictorial menus so people could choose a meal that visually appealed to them. Staff also showed people the choice of food on offer at lunchtime, rather than just informing them what was available.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Due to the restrictions imposed through lockdown and COVID-19, outside activities and outings had been curtailed.
● Staff had organised activities for people in the home. For example, in one household [unit] we witnessed people engaging with staff during a quiz. People were interested in responding and finding out what the right answer was, which was then discussed. People were encouraged to reminisce on their life experiences that were relevant to the quiz.
● A theatre group had recently provided entertainment for people outside, which had been enjoyed.
● Social media was used to enable people to maintain contact with those important to them.
● The home had re-opened to visitors by appointment. One person became upset and told us they were worried about their relatives who they had not seen for some time. Staff reassured them and told us this person's family had visited a couple of days before, and maintained daily contact by phone. Sadly the person had forgotten that the visits and telephone calls had taken place.
● People had visiting care plans which considered their risk of contracting COVID-19, and their capacity to understand social distancing.

Improving care quality in response to complaints or concerns
● Complaints were managed and responded to in line with the provider's policy.
● The complaints log showed that each complaint was addressed, the complainant informed on the outcome of the complaint, and what lessons were learned as a result of each complaint.

End of life care and support
● At the time of the inspection, no-one was receiving end of life care.
● Care plans included information about people and their family's wishes for how they would like to be

cared for as they reached the end of their life.

● The management team told us that during lockdown, people who had been on end of life care were able to receive visits from their relatives. Steps were taken to ensure these visits were conducted safely and in line with best practice.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- This inspection was prompted in part due to concerns about the oversight and management of the home. The last manager had de-registered in February 2021, and the deputy manager and clinical lead had left.
- Changes had been made to the management team and in the day-to-day operation of the home. Senior managers had worked closely with the local authority to make improvements, for example, in the management of medicines and responding to a significant number of errors that had occurred.
- People did not always receive personalised care that met their needs and preferences. There was a lack of management oversight to ensure personalised care was consistently provided in line with the butterfly approach. Haviland House follows the 'butterfly model' and the ethos is that each person living with dementia is unique, therefore, care is centred on the person, who is supported by staff in a family-like environment.
- Some personal information about people was framed and placed in the corridor outside their rooms. This related to people's likes and dislikes, or particular interests. However, we saw that it also included people's dates of birth, which is confidential information that should not have been put on display. We shared this with the management team at the end of the inspection, who agreed this was inappropriate, and this information would be removed.
- Staff told us how difficult life had been at the home during the pandemic. One staff member said, "Everything was going really well until January, when Covid struck. It was really hard and really sad. People became very sick quite quickly. We did everything to isolate and I didn't want to go out".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The manager had a good understanding of their responsibilities under duty of candour. They explained, "You have to be able to be transparent about how you run your service, report things in a timely manner, sharing information. It's about being honest when things go wrong and how you're going to put things right; that should be integral to the service".
- Significant changes had been made by the provider which had affected the management structure at Haviland House. A new manager had been appointed and was being supported in their new role by other senior managers of the provider. The new manager was in the process of registering with the Commission.

● Staff told us they were kept informed about the changes at the home through staff meetings. One staff member said, "Communication needs to be better, but it's hard to find the perfect system and they're working on it. Changes have been made and are needed; I like to be positive".

Continuous learning and improving care

● The home had been impacted by changes in the management team and COVID-19 which had a significant effect on people and staff.

● Senior managers had recognised the difficulties the pandemic and staff changes had made to the smooth running and safe operation of the home, and were working hard to make improvements.

● A variety of strategies had been implemented or were planned. For example, for staff through organised training sessions and provision of emotional support and counselling. The management team had not formally sought feedback from relatives about the home, but was in the process of planning how this could best be achieved.

● Shortfalls we found at this inspection had not been identified by the provider so actions could be taken and improvements made.

● Audits were completed in a variety of areas such as health and safety, infection prevention and control, care plan and risk assessment. A mock inspection had been undertaken internally and had identified a number of areas for improvement. An action plan had been drawn-up with timelines incorporated to ensure any improvements were completed.

● One staff member commented on changes at the home and said, "The timing is not the best because of COVID-19 and it can be unsettling. There have been lots of staff changes, but it's early days. Some shifts are running on less staff and it can be challenging".

Working in partnership with others

● The home worked in partnership with others. The manager told us of a regional group for managers which they had joined. This had helped them to understand more about the role of a registered manager through online meetings, and also through Yammer.

● A variety of health and social care professionals had recent involvement with the home. A visiting healthcare professional was aware of the problems the home had faced in the past, but talked positively about the changes that had been made in response. The healthcare professional identified there had been issues with record-keeping for monitoring people's health conditions. When they had informed staff of their concerns, they had been promptly resolved.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive personalised care that met their needs and preferences. Regulation 9 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people were not fully identified or assessed and information provided to staff to prevent risk of harm.<br><br>Regulation 12 (1) (2)(a)(b) |