Mrs S M Spencer

The Haven Rest Home

Inspection report

191 Havant Road
Drayton
Portsmouth
Hampshire
PO6 1EE

Tel: 02392372356

Date of inspection visit:
30 October 2018
01 November 2018

Date of publication:
11 December 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

What life is like for people using this service:
People did not receive a service that provided them with safe, effective, compassionate and high-quality care. The management of risk and medicines was ineffective and placed people at risk of harm. Staff were not recruited safely and people and staff had mixed views about staffing levels. People's human rights were not always upheld as the principles of the Mental Capacity Act 2005 were not adhered to. People were not empowered to make choices and have control over their care and people were not provided with support that was personalised to them. The service was not well led and there was a lack of quality assurance processes in place. People told us staff were kind and treated them with respect and people lived in clean environment.

Rating at last inspection: The service was last rated as Inadequate and published on 22 September 2018. Following the last inspection in January and February 2018, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well-led to at least 'Good'. We found the provider had failed to achieve this.

About the service: The Haven Rest Home is a residential care home that was providing personal care to 18 people at the time of the inspection. It is registered to provide a service to 20 older people who may be living with dementia or physical disability.

Why we inspected: This was a planned inspection based on the rating at the last inspection.
Follow up: At the last inspection the service was rated 'Inadequate'. At this inspection the rating remained the same. Therefore, the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our findings below.

The Haven Rest Home

Detailed findings

Background to this inspection

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

Inspection team: Two inspectors and an expert by experience conducted the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: The Haven Rest Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection, there were 18 people living at The Haven Rest Home, some of whom lived with dementia.

The registered manager had left the service and a new manager had been appointed in June 2018 who was applying to become the registered manager. For the purpose of this report, they will be referred to as the 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.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We reviewed the actions plans that the service had sent to us in relation to the inspection that was carried out in January and February 2018. We used this information to help us decide what areas to focus on during our inspection.

This inspection included speaking with 12 people, three relatives, six members of staff, the manager and the provider. We reviewed records related to the care of six people and the medicine records for sixteen people. We reviewed staff recruitment, supervision and appraisal records for four staff. We looked at records relating to the management of the service, policies and procedures, maintenance, quality assurance documentation and complaints information. We asked for further information following the inspection including rota's, the training matrix and monitoring charts and these were received.

Inadequate

Is the service safe?

Our findings

People were not safe and not protected from avoidable harm.

Assessing risk, safety monitoring and management
•We found at the last inspection in January and February 2018 risks to people were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Whilst the management of risk of falls had improved at this inspection, concerns around other areas of risk management still remained.
•Risks to people had not always been assessed, monitored or mitigated effectively. For example, one person had sustained a pressure related injury yet the risks associated with skin breakdown had not been assessed. The same individual had also been assessed by the district nursing team and was identified to be at risk of choking. Despite this identified risk, no choking risk assessment had been undertaken or completed, this meant that the person was at risk of choking but this had not been assessed.
•Nationally recognised tools to aid risk management were not utilised by the provider and we found other people had risks associated with health conditions but these had not always been assessed. For example, one person was at risk of constipation and was prescribed 'as required' medicine for this, however, the medicine had not been given and no risk assessment had been developed. The lack of risk assessments placed people at risk of harm.
•Some risk assessments had been developed in relation to areas such as falls, nutrition and health conditions however, these were not always detailed or current and did not provide effective guidance to staff to mitigate these risks. For example, one person had a risk assessment in place regarding the management of their diabetes, this stated that if the person did not have their insulin administered by the district nurse they were at risk of hypoglycaemic attack. However, guidance from Diabetes UK 2017 confirms this is incorrect as a lack of insulin causes high blood glucose levels. The risk assessment also stated that blood sugars needed to be checked if the person's behaviour was unusual but there was no guidance about what the person's behaviour was normally like or what the blood sugar should be. When we discussed this with a member of staff they told us the staff at The Haven did not check blood sugars. This meant that people were placed at risk of harm because staff did not have the correct information to keep people safe.
•The provider had recently recruited new staff who were not familiar with people's individual needs and staff were not always aware of risks to people.For example, one staff member did not know that a person had a pressure sore. Long standing staff were not always aware of risks associated with people who had been recently admitted. For example, one person had risks associated with taking a medicine that thinned their blood but staff did not know about this. This placed people at risk of health complications as staff would not know what signs to look for if the person was suffering from side effects associated with this medicine.
•Most areas of the environment were safe. However, a room that was in the process of being decorated was left open, we saw a drill in a communal area and medical gloves were accessible to people. This could pose a risk to people with dementia. There had not been a health and safety audit or any recorded checks of the environment carried out.
•The business manager had completed a fire risk assessment. This stated it was to be read in conjunction

with people's Personal Emergency Evacuation Plans (PEEP). PEEPS were not clear, accurate or up to date. For example, one person's PEEP stated they needed one person to assist them to mobilise but they needed two people to help them. This could cause confusion and delay in people being assisted to a place of safety in the event of an emergency.
•The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

•We found at the last inspection in January and February 2018, medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found this had not improved and people were not protected from the risks associated with the unsafe management of medicines.
•Two people's Medication Administration Records (MAR) contained gaps which meant there was no record that these people had their medicines as prescribed. These errors had not been identified or acted on to protect people and ensure the safe management of their medicines. This meant that these people could have become unwell because they hadn't received their medicines as prescribed.
•People did not have any guidance in place regarding their 'as required' (PRN) medicines. This meant staff did not have the information to tell them what the medicine was for, when someone may need it or how much to give. When staff had administered these medicines, they had not recorded the outcome for the person after receiving the medicine. This meant the efficacy of the medicine could not be reviewed.
•Creams were applied by carers. Some topical MARs lacked detail and stated, 'apply as directed' and body maps were not completed. This meant there was a lack of direction for staff to know where and how often to apply prescribed creams for people.
•Safe practice was not followed to ensure people's medicines were safely stored. No temperature checks were being undertaken of the medicines fridge. We observed that the temperature was too low for the medicines which were kept in the fridge. However, the fridge and the thermometer was full of water. The fridge was replaced on the day of inspection and the manager told us they would begin to record temperatures daily.
•Staff were trained to administer medicines, however records demonstrated only four out of 12 staff had been as assessed as being competent to administer medicines.
•The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Learning lessons when things go wrong

•Risk assessments and care plans were not always reviewed following incidents. For example, accident records demonstrated that one person had fallen twice while being at The Haven but their falls risk assessment stated, 'Name has not had any falls while at The Haven'.
•The provider had a system to record accidents and incidents. However, an analysis of accidents and incidents had not taken place, themes and patterns had not been identified and preventative measures had not always been put in place. For example, there was an incident record which demonstrated one person had displayed behaviour that challenged and this had caused an accident. An investigation of this had not taken place and measures had not been implemented to reduce the likelihood of this happening again.

Safeguarding systems and processes

•When we asked people if they thought the service was safe, comments included; "I do feel safe with most of

them, although at my age I don't expect too much" and "Yes, I do". All staff we spoke with thought the service was safe.
•Not all staff had a good understanding of safeguarding despite most staff having received training in this subject area. When we asked staff about this, responses included, "I'm not sure what you mean" and "I don't know what to say". When prompted, staff could describe some different types of abuse and were confident to report concerns to the manager. However, staff were not aware of who to report safeguarding concerns to if the manager was not available.

Staffing levels

•Recruitment practices were not always safe. Five staff members had started working prior to satisfactory employment checks being completed. This included suitable references and a Disclosure and Barring Service (DBS) check. The DBS carry out checks on individuals who intend to work with children and adults, to help employers make safer recruitment decisions. The provider told us these staff were continuously supervised while they were waiting for the checks to be received, however, rotas demonstrated some staff members were not always supervised. This meant that staff unsuitable to work with adults at risk may have been employed to work at The Haven. The failure to ensure staff were suitable to work with adults at risk was a breach Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.
•At the last inspection in January and February 2018 there was a mixed opinion of whether there were enough staff to keep people safe and meet their needs. At this inspection, this view was continued. Comments from people included, "Staff always seem to be there when needed", "I don't use the bell because I don't think they have time, they always seem to be so rushed" and "Staff have limited time". The management team felt they did not have enough time to complete tasks such as write risk assessments and care plans because they were not always given supernumerary time. We observed that staff were not rushed during the day of the inspection and call bells were answered promptly.
•At the last inspection in January and February 2018, we recommended that the provider used a systematic approach to ensure sufficient staff were deployed throughout the day. At this inspection we found this had not been done and the manager was unable to tell us how staffing levels had been calculated. The Hampshire Fire and Rescue Service recommended that to ensure there was a sufficient number of night time staff to evacuate people safely, a fire drill with two staff should take place but this had not been carried out. Therefore, we remain unassured that staffing levels in the service were sufficient to meet people's needs. We recommend that the provider seeks advice and guidance from a reputable source to ensure sufficient staff are deployed.

Preventing and controlling infection

•At the last inspection in January and February 2018 the service was untidy, unclean and malodourous in areas. At this inspection we found improvements had been made. The service was clean and we did not detect any areas of malodour.
•Staff were observed using gloves and aprons appropriately and they told us the manager had now ensured gloves were available in people's rooms which they found useful.
•There was no infection control audit in place, when we discussed this with the manager they told us they had planned to undertake one soon.

Inadequate

Is the service effective?

Our findings

People's care, treatment and support achieves didn't achieve good outcomes and didn't promote a good quality of life and is not based on best available evidence.

Ensuring consent to care and treatment in line with law and guidance

•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 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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.
•At the last inspection in January 2018, staff lacked an understanding of how to apply the principles of the MCA 2005. At this inspection, we identified continued concerns around staff's lack of understanding of the Act and continued failure to adhere to the principles of the Act. For example, when we asked staff what their understanding of the MCA was, comments included, "I don't know" and "I haven't been trained yet". When we checked whether the staff member had been trained, we found they hadn't.
•The application of the MCA 2005 was inconsistent, unclear and contradictory. A number of people had consent forms in place, yet it was unclear as to whether people had the mental capacity to consent to the decisions being made. Staff told us that a number of people were living with dementia, however, mental capacity assessments had not always been undertaken to confirm and demonstrate that people understood what they were signing for. Where capacity assessments had been undertaken and people were deemed to lack capacity, the provider was unable to demonstrate that best interest meetings had taken place.
•Three people living at The Haven had a DoLs applied for and two of these had been authorised. Records demonstrated that DoLs were not always applied for when they should have been. This meant the provider lacked an understanding on when to apply for a DoLs and people were potentially unlawfully deprived of their liberty.
•The failure to work within the principles of The Mental Capacity Act was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•People's needs were assessed prior to moving into the service, however there was no evidence that people's choices were taken into consideration. The pre- assessment form was mainly in a tick list format and did not contain information about how people would like to receive care and support with regard to their likes, dislikes and preferences. For example, people were not asked about their preferences around personal care or how they liked to spend their day. Care plans were not reviewed regularly or when people's needs changed.

•The provider did not always consider national guidance or standards. For example, The National Institute of Clinical Excellence (NICE) provides information about the management of medicines but this had not been followed and the environment had not been designed in line with available guidance from Social Care Institute for Excellence (SCIE).

Staff skills, knowledge and experience

•People and relatives provided a mixed view about the skills of the staff. One relative told us, "I have no reason to doubt their ability" and one person told us, "The staff are variable, some are well trained and some are not".
•The provider monitored staff training on a spreadsheet matrix which gave details of when individual staff had completed training considered essential to their role. For example; infection control, food hygiene, fire safety, safeguarding, dementia awareness, mental capacity and DoLS awareness and moving and handling. At the last inspection in January and February 2018 we found that staff members demonstrated a lack of understanding about the training they had received. We found at this inspection, staff still lacked an understanding, although two of the staff spoken with had been recently employed. For example, three staff members were unable to tell us about mental capacity and safeguarding.
•New staff received an induction and were given an induction checklist to complete which covered all aspects of the home. However, we found induction checklists were incomplete. The manager was unable to tell us why. New staff without prior care experience were not enrolled on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. The business manager told us after the inspection that these staff would be enrolled on the Care Certificate. New staff told us they shadowed a more experienced staff member until they felt confident to work alone and told us they found this period useful.
•Not all staff had received regular supervision or had an annual appraisal. The manager told us they had started these and had planned to make them more regular. Despite, the lack of formal supervision, staff told us they felt well supported in their role. One staff member told us, "I could go to the manager or senior with anything".

Eating, drinking, balanced diet

•People had mixed views about the food. Comments included, "When the business manager cooks, the food is better, they are on holiday at the moment so I don't expect it will improve until he gets back", "The food is excellent, some people moan about it, but it's fine for me" and "The food is good".
•People told us they had enough to eat and drink and records demonstrated people maintained a stable weight.
•Staff told us people could have an alternative choice if they didn't like the food on offer. One person told us, "I have to have what's given". We observed people in the dining room were all given the same meal on the first day of inspection, this meal was not a choice that was presented on the menu. When we discussed this with the provider, they told us, all people had chosen this option earlier in the day. We observed people were not offered a choice of drink with their meal or during the afternoon. The failure to provide people with person centred care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff providing consistent, effective, timely care

•Staff worked well with external professionals to ensure people were supported to access health services

and had their health care needs met. We observed that the district nurse was involved with supporting a person at the end of their life.
•Staff told us they worked well as a team and described the handover process where they could pass on information to each other about people's changing needs.

Adapting service, design, decoration to meet people's needs

• Since the last inspection the provider had made some changes to the environment. They had redecorated and re-carpeted the ground floor. A beauty room for people to have their hair and nails done had been created and chairs in communal areas had changed.
•Staff confirmed that people had not been involved in decisions about the redecoration of the environment. However, people could personalise their rooms as they wished.
•Efforts had begun to be made to make the home dementia friendly, people's names and some pictures were on their bedroom doors. However, more was needed to continue with this. For example, more signage was needed to help people orientate themselves and consideration was needed with the redecoration project to ensure this would be useful for people with dementia. For example, we saw the handrails were painted in a similar colour to the walls which would make these hard for people to see.

Requires Improvement

Is the service caring?

Our findings

The service doesn't involve or always treat people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported

•People and relatives were positive about the staff and said they were treated with kindness. One person told us, "The staff are lovely they are very kind to all of us, we get along as a kind of family". However, despite people's positive comments about the staff team, we identified areas of practice which were not consistently caring. The provider had not ensured people were adequately supported in terms of protecting their rights, ensuring that risks and medicines were managed safely, providing stimulating activities and ensuring people could provide feedback about their care and the service which was acted on. We have discussed the associated risks of this within the 'Safe', 'Effective', 'Responsive' and 'Well-led' section of this report.
•We observed a lack of engagement between staff and people during the inspection, however, when staff did talk to people, they did this respectfully and kindly. For example, when a staff member was administering medicines, they took time to talk with people.

Supporting people to express their views and be involved in making decisions about their care

•There was no evidence to suggest that people had been supported to express their views. For example, no one was asked how they wished to spend their time during the day of inspection. We saw that a member of staff put on a Christmas film for people to watch but we did not observe anyone watching it.
•People told us they were not actively supported to be involved in decisions about their care. One person told us "I don't feel the need to give my opinion, the staff just get on with it". There was no evidence in care records that people had been involved in decisions about their care.
•The Accessible Information Standard is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The manager was not able to provide any examples of how this act was adhered to. The failure to provide people with person centred care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Respecting and promoting people's privacy, dignity and independence

•Staff were able to tell us how they would protect people's privacy and gave examples such as closing doors when assisting with personal care. One member of staff told us about 'please do not disturb' signs that were put up when assisting a person with personal care. We observed during the inspection that staff knocked on people's bedroom doors before entering. However, we saw that personal information about people was left in a communal area. This meant that people's right to privacy and confidentiality was not respected.
•People and staff told us people were treated with respect. One person told us "I am treated with respect and they are all very kind". One member of staff described the importance of maintaining people's independence and provided examples of how they did this.

•The Equalities Act 2010 is designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. There was no evidence that people's preferences and choices regarding these characteristics had been explored with people or had been documented in their care plans. However, we saw no evidence that anyone who used the service was discriminated against and no one told us anything to contradict this.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that responded to their needs.

Personalised care

•At our last inspection in January and February 2018, we found people did not receive care and support that was personalised to them. At this inspection we found people were still not receiving person- centred care.
•There was no evidence that people were empowered to make choices or have as much control and independence as possible, including developing their care and support plans. One person told us, "I didn't know I had a care plan, I've never seen it". The manager told us reviews of people's care had not taken place since they had been in post (June 2018).
•Care plans were not person-centred and lacked information about people's needs, wishes and preferences. For example, staff told us about a person who could display behaviour that challenged. Their emotional well-being care plan only stated that 'staff should observe (person) when they are interfering with other residents'. There was no information about how this person needed to be supported to alleviate their agitation or what made the person happy. Two people who had been admitted into the Haven Rest Home three weeks and one week prior to the inspection, they did not have a care plan in place. This meant that staff did not have the information to care for people in the way they preferred.
•We observed people spent most of their time without stimulation and engagement from staff. Throughout the morning of the first day of inspection, people were sitting either in the lounge or their rooms, the television was on in the lounge but people were not watching it. Ten of the 18 people were engaged while they took part in a quiz activity during the afternoon, however, people only had access to activities four afternoons and one morning per week. Care staff told us they did not take part in activities, the manager confirmed this and said it was because staff did not have time. The manager told us people only went out with their families and no outings were organised for people by the home.
•Some areas of daily activity were task led by staff. For example, people had a bath on certain mornings depending on what room number they were. The manager confirmed people were not asked when they would prefer a bath. Not all care plans detailed when people wished to get up or go to bed, where they liked their meals or how they liked to spend their day.
•The failure to provide care and support that met people's needs and preferences was a continued breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

•We viewed the complaints file and saw that people's complaints were investigated and responded to. The manager had put measures in place to reduce the likelihood of these issues reoccurring. However, there was no analysis of complaints to identify themes or make improvements at a service level.
•We saw that some concerns had been raised but these had not been recorded in the complaints file. This meant that there was no system in place to see how people's concerns had been addressed or to understand any emerging themes or patterns of people's concerns.

End of life care and support

•People did not have end of life care plans in place when they were receiving end of life care. This meant that staff were not aware of people's preferences at this time.
•Staff had not received training on end of life care, however, healthcare professionals were involved as appropriate.
•People's families were supported while people were receiving end of life care.
•The service sourced specialist equipment and medicines at short notice to ensure people were comfortable and pain free.

Inadequate

Is the service well-led?

Our findings

Leadership and management of the service did not assure person-centred, high quality care and a fair and open culture.

Plan to promote person-centred, high-quality care and good outcomes for people

•Person-centred care was not promoted in the service and people did not always receive high quality care. This has been demonstrated in the other domains of this report. One person told us, "It's alright here, you must remember that it is not a hotel, you cannot expect pristine service and the staff have a lot to do and another person told us, "I don't think the service is up to much, although some of the staff are very good".
•The service was not open or transparent. Information had not been given to people or relatives about the home being in special measures. When things went wrong or people came to harm, apologies and an explanation were not always provided for people. The manager confirmed that the requirements of The Duty of Candour had not been met. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•Staff told us they felt supported and valued by the manager, the deputy manager and the senior care assistant. However, not all staff felt they were treated fairly or supported by the business manager. For example, a member of staff told us the business manager had told staff it was their fault the home was in special measures which made the team morale low. We discussed this with the business manager following the inspection and he confirmed that he had held a staff meeting where it was stated that it was everybody's fault the home was in special measures including their own.
•Staff demonstrated commitment to the people living in the home and told us they wanted to provide good quality care to the people living there. The manager told us they were determined to make improvements at The Haven so people experienced a good quality of life.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

•The manager had been in post since June 2018. They told us that during this time, a clear management structure had not been developed and they were not always certain of their role. This was because the provider and business manager had not been clear about the responsibilities that each member of the management team held.
•At the last inspection in January and February 2018, quality assurance processes were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•At this inspection we found the quality assurance processes continued to be ineffective and did not pick up on the issues identified at inspection. These included concerns with recruitment, records, risk management, medicines and a lack of person centred care. Some care plan audits were in place but these were a tick list exercise and did not contain any identified actions. Medicine audits were infrequent and did not identify the

concerns we found with medicines. Accident and incident audits were also tick list and accidents and incidents were not analysed so trends or patterns could be identified. There were no other completed audits in place.
•Numerous concerns were identified with records. These included incomplete, inaccurate and conflicting care plans, risk assessments that were not detailed, gaps in medicine records and inaccurate information in the controlled drugs book, inaccurate PEEPs and a lack of monitoring charts for people. There was a risk that if robust records were not put in place, this could negatively impact on people's health, safety and well-being. A failure to have effective systems and processes in place to monitor and mitigate risks to people and maintain an accurate, complete record in respect of each service user was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
•At our last inspection we found a failure to notify CQC of significant events that happened in the service. At this inspection we found one notifiable incident that had not been reported to us. The manager told us this was because they were absent from the home when this happened and no other staff member had done it. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
•Providers are required to display their current rating. However, we found that this had not been done. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff. Working in partnership with others.

•There were no records that demonstrated people or their relatives had been involved in decisions about their care or the running of the service. Surveys to gain feedback about the service had not been sent out. Meetings for people were held every three months by the activity coordinator. Feedback was sought but there was no recorded action about how improvements had been made. For example, one person had said their clothes were missing and another that the food was served with water on it but no action had been recorded to state that these issues had been rectified. This meant that the views from people involved with the service had not been considered or acted upon to make improvements. Meetings were held every month for staff but the minutes of these did not demonstrate that staff views had been sought.
•The manager told us that there were very few links with the local community but some people received visits from their local church.
•A team from the local authority had been working alongside The Haven to help the home improve the quality and safety of the service provided to people. This is a project that supports other homes in the area. The manager told us this was useful.

Continuous learning and improving care

•Despite the service being in special measures, there was no improvement plan in place. The manager confirmed that improvement in the service had been slow and felt they "Never had a constructive day". The manager had been sending the Commission monthly action plans which detailed what was being done to make improvements since the last inspection, however, these were not robust and during the inspection we observed that the improvements had not been made. For example, it stated on the action plan that care plans had been completed to the new format but we found information in the care plans that was not reflective of people's current needs or that was person-centred.
•Incidents did not prompt learning to improve care. For example, we saw from the communication book that the manager had written a message to staff about identified medication errors. Another staff member had also recorded that tablets were found on the floor. The medication error process had not been engaged and there was no evidence that these had been followed up or that staff had learnt from these incidents to improve care for people.

•There were no actions identified in the audits that were in place which meant improvements could not be made.
•A social care professional told us they had offered advice about how to make improvements in the service, however we found at this inspection, it had not been followed.
•Breaches of the same regulations were found at this inspection as the last which demonstrates learning and improvement had not taken place. The provider also failed to act on recommendations regarding assessing staffing levels that were made by CQC at the last inspection in January and February 2018.