Mrs S M Spencer

The Haven Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Haven provides accommodation for up to 20 older people living with dementia. There are 18 single rooms and 1 shared room which are arranged over two levels. There is an enclosed garden. At the time of inspection 19 people were living in the home.

The inspection was unannounced and took place on 9 January 2018. Following this, we received concerns about the care provided at The Haven so we carried out another unannounced inspection visit on 7 February 2018.

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

At our last inspection, on 06 January 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines administration recording were not completed appropriately and in line with national guidance. The provider had taken action in relation to the concerns we raised during that inspection. However, we found other concerns which led to a continuing breach of this Regulation. There was also a breach of Regulation 17. The quality assurance system had not been robust and auditing had not always identified where improvements were required. At this inspection we found a continuing breach of Regulation 17.

We found at this inspection that there were new breaches of the Regulations.

Some risks associated with the management of medicines and people's care and treatment had not been identified because effective checks were not undertaken.

There was not a robust quality assurance process in place. Audits to assess the quality of service provision were ineffective in identifying improvements needed. Action plans were not developed to ensure improvements were made.

Feedback from people was sought. There was a complaints procedure in place; these were investigated but not adequately resolved for people.
Allegations of abuse, incidents and accidents were not always investigated thoroughly by management.

The home was not always clean and in some areas of the home there was malodour.

Staff had completed training in line with the provider's policy. However, some staff did not demonstrate an understanding of what they had received training in.

Staff sought verbal consent from people before providing support, but did not always follow legislation designed to protect people's rights when making decisions on their behalf. Care plans had some mental capacity assessments in place but these were not reviewed when necessary.

Staff had not always notified CQC of significant events that occurred in the home.

People were supported to access other healthcare services when needed. They enjoyed the meals provided; however people did not have their food and fluid intake adequately monitored.

People were complimentary about the staff. Interactions we observed between staff and people were positive. Staff encouraged people to remain as independent as possible, however people's privacy and dignity was sometimes compromised.

People told us they were satisfied with the activities in the home but people's spiritual needs were not met.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

Full information about CQC's regulatory response to any 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.

Risks had not been appropriately assessed and mitigated to ensure people's safety.

Medicines were stored, administered and disposed of safely. However, where people were prescribed 'as required' medicines to help with pain and anxieties there was not clear systems in place to ensure these were given appropriately.

The home was not always clean and there were areas of malodour.

The provider did not use a systematic approach to ensure there was enough staff on duty at all times of the day.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 (MCA) had not been followed. People's capacity regarding some decisions had not been assessed and when it had, it was not regularly reviewed. DoLs had not always been appropriately applied for.

Staff training was up to date but some staff lacked essential knowledge to enable them to support people effectively.

People were supported to eat and drink enough; however, food and fluid intake was not adequately monitored. .

Staff were appropriately supported in their role and arrangements were in place for them to receive supervisions and annual appraisals.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives mostly said staff treated them well. Staff knew people well.

Whilst most interactions between staff and people were positive, we observed people's privacy and dignity were sometimes compromised.

People were encouraged to remain as independent as possible.

Is the service responsive?

Inadequate

The service was not always responsive to people's needs.

Care plans did not always contain enough information to enable staff to provide person centred care to people.

There was a complaints procedure in place, complaints were investigated but not satisfactorily resolved.

Some daily activities were task led and people's spiritual needs were not always met. People told us they were satisfied with the activities in the home.

The provider did not have robust arrangements in place to ensure people received appropriate end of life care.

Is the service well-led?

Inadequate

The service was not well-led.

There had been insufficient oversight to recognise a decline in standards of safety and quality.

An effective quality assurance system was not in place. This had led to breaches of multiple regulations.
Audits were not robust and action plans had not been implemented.

The provider had not notified CQC of all significant events.

Staff told us they enjoyed working at the home and that management was supportive.

Feedback about the service had been sought using surveys and meetings and information had been acted on.

The Haven Rest 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 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.

The inspection was unannounced and was carried out on 9 January and 7 February by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We had also received concerns about aspects of the care people had received.

We spoke with eight people and five relatives of people living at the home. We spoke with six members of staff, an activity coordinator, the registered manager, the business manager and the provider. We also spoke with a community matron, a nurse, three social workers and a professional from the Care Home Team. We observed care and support being delivered to people in the communal area of the home.

We looked at care plans and associated records for 10 people using the service, staff duty records and other records related to the running of the service, including staff recruitment and training records, accidents and incidents, policies and procedures and quality assurance records.

We asked for some information such as rotas, policies and people's records to be sent to us after the visit. This information was received.

Inadequate

Is the service safe?

Our findings

People told us they felt safe in the home and staff were available to help them. Comments from people included "Yes I am very safe, because everybody here is so nice, they look after us", "oh yes, we have people we respect that look after us, facilities are good and reputation are good" and "Oh yes, I am safe, I have been here for four and a half years, staff are good, I am comfortable".

Our inspection of 6 January 2017 found that medicines administration recording had not been completed appropriately. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had taken the necessary action to address this. However, other concerns were found in relation to medicines.

Some medicines are prescribed to be taken when required (PRN). Records showed that when people were prescribed these medicines information was not available to guide staff as to what the medicine was for, when and how much to use. Staff did not record on the back of the medication administration record (MAR) when and why as required medication was given.

We discussed this with the registered manager on the first day of inspection and we found that on the second day of inspection, the provider had put some guidance in place for medicines that are to be taken when required. However, we found that these protocols did not contain the necessary information to guide staff.

We checked to ensure the correct amount of medicines were in their packets. All the medicines that we checked were correct apart from one. This was because the care assistant had signed to say they had given the tablet before it had been administered. The care assistant told us this was not the usual practice and knew it was not the correct procedure.

The failure to fully 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.

Staff told us they checked the MAR's for any missing signatures daily and if there were gaps they would act on it to ensure people received their medicines as prescribed. We saw the MAR's were completed appropriately. Medicines were stored safely. Stock levels were checked regularly. When medicines were no longer required, they were disposed of safely. Temperatures were monitored which meant that staff ensured medicines were stored within recommended temperature guidelines. We observed a medicines round. The care assistant administering the medicines checked people were happy to have their medicines, didn't rush them and waited until they had swallowed before leaving them.

People were not protected against the risk of skin damage. One person had a pressure sore. There was no guidance about repositioning or applying creams for the person. The annual skin and hygiene review dated 2 January 2018 also gave no guidance to staff on repositioning the person or applying creams. There was also nothing documented about the progress or evaluation of the wound.

Records indicated that the person was not repositioned before the 25/01/2018 despite having a pressure sore in September 2017. Staff confirmed this, one member of staff told us "We started turning the person about a week before they left the home; we were not told they needed bed rest before this, they sat in their chair". Another staff member said "(Name) needed turning towards the end of their time here".
The registered manager told us they assisted the person to have bed rest in the mornings because they knew the person had visitors in the afternoon. There were no records to support this.

We discussed this with a District Nurse and they told us they were concerned that the person's continence needs had not been met by the home and when they visited they frequently found that the person's dressing had come off which meant the pressure sore got worse. They raised concerns with the local authority in November 2017 and January 2018 about this. The person moved to another home and on admission it was noted that the person had three more pressure sores, when we discussed this with the registered manager they told us that these were not present when the person moved from The Haven.

Another person had seen the District Nurse in January 2018 because they had a sore on their sacrum which needed dressing. This had healed when we inspected the service. There was a record of this on the person's body map; however there was no information about the progress or evaluation of this. The person had also lost six pounds in weight in one month. On the person's monthly skin and hygiene review it stated "there is a skin pressure cushion in place". We saw that the person was sitting on a hard commode chair and their pressure cushion was beside them. These factors would increase the risk of the person sustaining a pressure related injury.

We found risks from falls had not always been adequately assessed or managed. People had a falls risk assessment in place and had been assessed at being at low, medium or high risk of falls; however there was no rationale about how this level of risk had been calculated. We found that some people had been assessed at being at low risk of falls but there was conflicting evidence which meant they were actually at high risk of falls. For example, one person's falls risk assessment which was reviewed on 26/1/2018 stated they were at low risk of falls and used a zimmer frame to mobilise with the minimal assistance of one care staff. The registered manager told us they had no falls. However, the falls tracker showed they had a fall on 28/12/2017.
Another person's falls risk assessment stated they were at low risk of falls but they had fallen five times since November 2017. One of these falls required a paramedic to attend.

This meant that the risks of people falling had not always been assessed effectively so preventative measures could not be put in place to mitigate these risks for people.

Some people displayed behaviours that challenged. A member of staff had recorded in the handover book that one person 'elbowed me twice and became very aggressive, picking up a bottle of water, going to throw it at me'. Entries in the person's daily records also showed that the person hit staff. We saw in this person's daily notes there were numerous entries showing the person went into other people's rooms causing them distress. Although the service had sought the advice of the community psychiatric nurse there was no risk assessment in place and no plans to reduce these risks had been developed.

Staff told us another person was becoming increasingly "agitated and intimidating". Daily notes confirmed this and we saw an entry in the handover book that they had displayed behaviours that challenged which scared another person so much they became incontinent. The person was being supported by the community mental health nurse and their medication had been changed in order to help calm them. However, on the person's general risk assessment there was a section titled 'physical violence/aggression to others where a '0' was circled which denotes the person did not present a risk.

Risks of health complications had not been assessed and plans implemented to reduce the risks. Two people's care records identified a risk of developing urinary tract infections (UTI's). UTI's in older people can impact significantly on them, however no assessment of this risk had been made and no plan developed to mitigate the risks. To reduce the risk of UTI fluid intake should be encouraged, however records did not reflect that people's fluid intake was monitored to ensure they had a sufficient fluid intake to reduce the risk.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was at risk of poisoning due to ingesting liquids that were meant for washing. There was a risk assessment in place and the products were stored in a safe place.

At the last inspection of 7th January 2017 it was noted there were some areas of malodour in the home. We had also received other concerns about the cleanliness of the home prior to this inspection. During the inspection, there were areas of malodour around the home; some areas were stronger than others. One staff member told us they couldn't smell it whilst another staff member said "sometimes, it does smell of urine in here". A third staff member told us "the chairs smell, I don't like sitting on them". When we discussed the malodour with the registered manager, they were unable to account for it.

Cleaning schedules were in place and housekeeping staff recorded all the cleaning that had been completed, including deep cleans of people's rooms. However, the home was not always clean and we observed some areas that could pose a risk of cross infection for people.

There was dirty laundry in a bath and in the same bathroom; the floor and toilet were stained with what appeared to be faeces. When we went to check later, the laundry had been removed and the bathroom cleaned. In one person's room they had a table which had spilt food and drink stuck to it. A care assistant put a tray of food on top of this without cleaning it first. We saw that one person was spitting on the floor while they were sitting in the lounge. We were told by a staff member that this was a frequent habit. This was not cleaned straight away. When we discussed this with the registered manager, they were unaware of the issue and said they would buy a spray.

At 11:30 on the second day of the inspection three people's carpets in their bedrooms were dirty and four people's commodes were stained and dirty. We had received a concern that one person's commode was often full of urine and faeces and when we checked this it was. In another person's room there was rubbish and a tissue on the floor which had blood on it. Another person also had rubbish in the corner of their room. When we discussed this with the registered manager they told us it was because the bedrooms were not cleaned until midday. This meant that people spent the mornings in an environment that was not always clean.

There were some areas of disrepair in the home. In one person's room the curtains were ripped and falling down. Numerous doors were scuffed and some of the lounge furniture looked old and tired. On the second day of the inspection we saw that the provider had begun a redecoration programme.

The failure to ensure the premises were always clean and free from odour was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection on the first day we saw a moving and handling procedure that appeared unsafe. The registered manager told us they had investigated this and concluded the action taken by staff was necessary

given the circumstances. On the second day of inspection we asked to see the investigation records and the registered manager told us they hadn't made any. We further asked about safeguarding incidents that the local authority had told us about and the registered manager told us there were no written investigations of these. Due to the lack of documentation there was no evidence that when things went wrong, investigations and reviews were sufficiently thorough. We were unable to see what improvements had been made in relation to incidents.

We checked to see if appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring System (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. All staff that we saw files for began work before their DBS had been cleared. We discussed this with the registered manager and they told us they used this as a trial period and staff were not able to work alone. We saw that two staff members had a risk assessment in place for this but the other one did not. The registered manager told us there should be one and thought it had been misplaced. References were obtained in line with the provider's recruitment policy.
There was a record of staff being interviewed to assess their suitability for the post.

Prior to the inspection we had received concerns about a shortage of staff, particularly in the evenings. We looked at the staff duty rota for a four week period. They showed that there were four care staff, one cook and one cleaner on duty between 8am and 2pm. For the remaining hours there were two or three care staff on duty. There was also an activity coordinator on duty between 2pm and 4pm every week day and for two hours in the mornings at weekends.

Our observations showed people were responded to quickly and staff did not appear to be rushed. When we asked people if their calls bells were answered in a timely way we had a mixed response. Comments included, "I don't think so", they were very prompt", "they were quite fast" and "When there are only two on I am careful with my buzzer because if the door goes or someone falls you can't get anyone. They need more staff if they are looking after someone and you are waiting, sometimes you have to wait".

All staff we spoke with told us there were enough staff on duty in the mornings. We asked staff members about staffing in the evenings. One member of staff told us "it is manageable" and another said "it is enough". However, another staff member told us "It can be hard with two staff, we should have another girl on". A relative told us "the staff don't have time to sit down and talk to people". When we discussed our concerns with the registered manager they were unable to demonstrate how staffing levels were calculated to ensure there were sufficient staff available at all times. They said they would employ more staff if it was felt necessary.

It is recommended that the provider research the use of a systematic approach to determine staffing levels based upon people's dependency and level of need

Most staff had been trained to deliver first aid. A programme of health and safety checks were conducted; this included regular testing of electrical equipment, hoists, call bells, hot water temperatures and fire safety.

People had personal emergency evacuation plans (PEEPs) in place. PEEP's describe the support and assistance that people require to reach a place of safety when they are unable to do so unaided in an emergency. Some staff members were not clear about the action to take in the event of a fire and staff could not remember taking part in a recent fire drill.

It is recommended that the provider puts in place systems to ensure staff know what actions to take in the event of a fire and that these actions are practised on a regular basis

Staff said they had received safeguarding training and knew how to report any signs of abuse. Additionally, staff were familiar with the term "whistleblowing" and said they felt confident to raise any concerns about poor care. All of the staff said they believed that any concerns they raised would be taken seriously. One member of staff said "I've had safeguarding training; if I had a concern I would go to the manager or take my concern to CQC if I needed to". Another said; "I would report concerns to the manager".

Requires Improvement

Is the service effective?

Our findings

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The provider was not working within the principles of The Mental Capacity Act 2005 (MCA). Mental capacity assessments regarding living in the home were in place. These were completed when a person was admitted to the home. However, these were not regularly reviewed and information contained within the mental capacity assessment and care plans was sometimes conflicting. For example, on one person's mental capacity assessment it stated they were able to retain information but on another area of their care plan it was recorded that their dementia affected their short term memory and they often forgot what they just said.

This meant that some people may no longer have had the capacity to make decisions about their living and care arrangements. We discussed this with the registered manager on the first day of the inspection and on the second day of inspection we saw that two people's mental capacity had been reassessed in relation to living in the home.

When we looked at people's personal monies records we saw that their money had been spent on items such as tissues, activities, raffles and flowers. The provider told us they asked people if they wanted to spend their money in such a way if they had capacity and if they did not they asked their relatives. There was no evidence of this. A relative told us they were unhappy with this arrangement as they were not asked and they did not think their relative had the capacity to understand what was being asked.

In addition we were told that a decision had been made by the home to block off a person's toilet as they were at high risk of falling in there and given a commode instead. We asked the person how they felt about this and they did not appear to understand.

These people's capacity to provide consent to staff undertaking these decisions had not been assessed and there were no records to demonstrate that best interests decision making had been applied. This meant there was a risk that significant issues within people's life were being managed by others without the person's consent or in a way that ensured their best interests.

People had a 'consent to care' record in their file. Some of the consent forms had been signed for by the person's next of kin even though the person had been deemed by the service to have capacity. If the person had capacity, then decisions should not have been made on their behalf as this would have compromised their rights. We discussed this with the registered manager and they told us that they would review this.

Despite the procedures not being robust, we saw staff asking for people's consent before any care was given.

We saw that staff sometimes gave choice to people. We observed a staff member asking whether a person would like to go to their room or in the lounge. The person chose to go to their room and the staff member assisted them there.

However, on another occasion we heard a staff member say to another "Put that quiz programme on the TV, they (people) like that." No staff member asked people what they would like to watch.

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 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.

On the first day of the inspection two of the 19 people had a DoLs applied for and these had been requested by an external social care professional. Providers must carry out a two stage assessment to determine whether a DoLs should be applied for. There was no evidence that this had been carried out.

We asked staff whether some people who did not have an application of DoLs would be able to leave the home of their own free will. One staff member said "Crikey, no" another said "Definitely not". When we asked them why, they replied "They are not in the right mind space" and "It's not safe".

Our findings meant that people may be being deprived of their liberty unlawfully.

We saw that on the second day of inspection two more people had a DoLs applied for.

The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The matrix showed that staff were up to date with their required training. Some staff had undertaken extra training such as diabetes management which was then cascaded to other staff in the home.

Staff members told us they had access to a range of training courses to enable them to have the ability to carry out their job to the required standard. However, some staff members demonstrated a lack of understanding in subjects that they had received training in. For example, when we spoke to staff about DoLs, three staff members told us they did not know what this meant. One staff member could not remember their induction or having received training in moving and handling and two staff members were unclear about the fire procedure

When we asked the registered manager whether new staff undertook the Care Certificate they told us they had used it in the past. 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. We did not see evidence in the staff files that we looked at, that those staff members had undertaken the Care Certificate. The staff members that we spoke with during the inspection told us that they had not done this. There was an induction book in place that was signed off when new staff had received that area of training.

We found that care and support did not always reflect current evidence-based guidance, standards and best practice. For example, the service did not use assessment tools in relation to pain, skin and on the first day of inspection, nutrition.

Some people's food and fluid intake was being recorded to monitor and evaluate their needs. However, these records were ineffective. There was no daily intake or output targets recorded on fluid charts to enable staff to evaluate people's needs. There was nothing documented within daily records to show that staff had recognised below average food and fluid intake or whether they had escalated their concerns to a senior member of staff when a person had eaten or drank a small amount. There was no accountability for checking and acting on the food and fluid information that was recorded.

We saw that people were being weighed regularly and support from health professionals was sought if someone had lost weight. Supplementary drinks and high calorie diets were given to people who needed them. However, a screening tool to identify adults who are malnourished and at risk of malnutrition or obese, was not in use on the first day of inspection. We discussed this with the registered manger and on the second day this was in place, however this needed to be further developed so people's nutrition care plans were reflective of this. The lack of evaluation of food and fluid charts and thorough nutrition care plans could put people at risk of malnutrition and dehydration.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

People mostly spoke positively about the meals, describing them as "good" and "lovely". One person told us "it's not too bad; it depends on who's cooking". We observed lunch in the dining area over the two days. The atmosphere was pleasant and relaxed. Some people ate at the dining tables and others in the lounge area. Staff assisted those that needed it and this was done sensitively with staff telling the person what the food was, asking if they enjoyed it and were they ready for more.

If people did not want the meal they had selected, staff told us they could make an alternative choice. A person confirmed this and told us "Yes, we get a choice".

In addition to the main meals, snacks were available throughout the day, including biscuits, cakes and fruit. One person asked for some fruit from the fruit bowl and a staff member said "of course you can, it's for you, you can have whatever you want".

People in the lounge had access to drinks at all times and were offered them regularly. We had received a concern prior to the inspection that a person's drink was kept out of their reach while they were in their room. When we looked at this we saw that most people had accessible drinks, however, one person did not have a drink in their room and another person's was out of their reach.

Some areas of the home were not suitable to meet the needs of people living in the home, especially those people living with dementia. The signage was not clear around the building for people with dementia to orientate themselves. Toilets and bathrooms were poorly signed, for example; one toilet door had the word toilet not standing out clearly and another did not have any signage at all. People's bedroom doors only had a number and did not have their name or any other identifying features in order for people to recognise their own door. There was a lot of signage around the home for staff. For example, there were posters in the lift and in corridors which reminded staff to carry out certain tasks. We discussed that this could be confusing for people living with dementia and on the second day of inspection these signs had been removed. There was a menu on display but this did not match what the meals were that day. There was a large window in

the lounge and people were able to see views of Portsmouth and the Isle of Wight from here. Most other areas within the home lacked a point of interest other than seating placed around the room and facing a TV.

We recommend the provider considers current best practice guidance on providing a dementia friendly environment to meet the specialist needs of people living with dementia.

Care assessments mostly explored people's diverse needs. These included age, disablity, gender, marital status, race and religion. However, the registered manager told us they did not cover people's sexual orientation. They told us they would adapt the assessment form to include this. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

Staff received regular one-to-one sessions of supervision and annual appraisal with their line manager. This was a formal process which provided opportunities to check performance and ensure staff were being supported appropriately. Staff told us that they found the supervisions to be effective and had helped to resolve any issues that they had previously had.

People were given support to attend regular appointments and to get their health checked. Staff sought advice from external health professionals when people's health and support needs changed. Records showed that referrals were made to external physical and mental health specialist teams when advice and support was needed and there was evidence that external professional's such as GPs and nutritionists were involved in people's care and support. When we spoke with a member of the care homes team, they told us they had been visiting the home to give support, however after a number of visits the service was declined. The care home team are an organisation which support care homes in delivering best practice in meeting people's care needs. They also offer specialist advice if there is a particular issue that someone may be experiencing.

Requires Improvement

Is the service caring?

Our findings

We had received concerns prior to this inspection that people were not always treated in a caring way.

We asked people if they thought the staff were caring. Everyone we spoke with replied positively. One person said "They are very nice if you want anything you only need to ask" and another said "Very much so". Relatives we spoke with were also positive in their responses which included "They are the kindest of people, they understand not only (Name) but us as a family and "Everyone is friendly and attentive, they look after Mum very well".

We looked at how people's privacy and dignity were protected in the home. Staff were seen to knock on people's doors before entering their bedrooms. They also asked or waited for people's permission before entering. All people we spoke to told us that staff knocked before entering their rooms. One person said "They always knock the door when they come to see me".
One staff member told us "I always keep the door shut when providing personal care". However, when we spoke to a person who shared a room with someone else they told us that "Some staff don't pull the screen across in the morning when I get washed and dressed". This meant that people's privacy and dignity could be compromised.

We saw that most people looked well presented with their hair done nicely and nails clean. However, we did note that two people were wearing clothes that were stained with food.

Some of the language used in the care plans was task orientated and words were used such as 're - padded', 'fed' and 'toileted'. This implied that people were having tasks done to them rather than being assisted with meeting their needs. A staff member described some people who lived in the home as 'demented' which does not reflect that dementia is an umbrella term for the symptoms and that there are different forms of dementia.

Some people's doors were open and they were lying in their beds. Where people did not have capacity, this should be considered a best interest decision. A person also told us that other people came into their room uninvited which caused them distress. They described a time where another person had turned the lights on and off and touched their knee. A staff member confirmed this and said one person took sweets from another person's room. We also saw records of when a person got into bed with another person uninvited.

The failure to ensure people's privacy and dignity is protected is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they believed their voices were heard in this service. All people thought they were. One person said "If you speak to any staff, they will listen".

Interactions we observed between staff and people were positive and showed staff knew people well. For example, one member of staff spoke to a person about their family member and another understood that

when a person asked to go home, they wanted to go their room. Staff used people's chosen name when speaking to them. One person told us "They use my name, they are very polite" and another said "They call me by my first name, and that makes us very friendly".

A lot of staff had worked at the service for a considerable length of time and told us this helped to get to know people well. One member of staff said 'we are like a family'.

We saw that staff and management spent time chatting with people individually. One person asked for the registered manager using a pet name and there was cheerful interaction between them.

Staff engaged with people, made eye contact, bent down to their level and used touch appropriately to reassure and we saw that where people requested support it was provided promptly and discreetly.

Most staff members told us they were able to provide people with personalised care because they knew people so well. However, two members of staff told us that it was sometimes difficult when there were only two staff on duty. A staff member went on to tell us that when people needed assistance with the help of two staff, other people in the home could not be assisted as there were no more staff available. This meant that on some occasions there may not have always been enough staff to ensure people received personalised care.

Staff were able to tell us how they promoted people's independence. One member of staff told us "I encourage them to do as much as they can for themselves". We asked relatives whether they thought the service promoted independence for people. Most relatives thought it did, one relative said ""As far as I know yes, they encourage her to move around, dress herself and walk around the building within her limit". However, another relative replied "I don't think so; they don't support her to walk around".

There were numerous task focused entries in people's care plans. The registered manager told us they had started some reflective accounts to ensure there were more person centred approaches. We saw a written account that 'the person seemed quiet, not the usual banter, asked them if they wanted to look at their photos and their eyes lit up'.

Inadequate

Is the service responsive?

Our findings

We asked people and their relatives if they were involved in their care planning. There was a mixed response, one relative told us "Yes, we are informed, if their need changes we will be informed by management and we will agree on the way forward", another relative said 'No' and a third told us 'I don't know'.

People's needs had been assessed prior to their admission to the home however; the information on the assessments was not used effectively to develop care plans.

Care plans lacked information in relation to people's physical, emotional, social and health needs. For example, the care plan of a person living with dementia did not include information about the type of dementia they had and how they could be supported with this. Another person who had diabetes did not have a care plan related to their health condition, while a third who had Parkinson's disease, glaucoma and osteo - arthritis did not have information about any of these health conditions recorded in their care plan.

Each person's care plan had 10 sections relating to different areas of need. We found that these care plans were not always detailed enough to sufficiently guide staff to provide support to people in a person centred way. For example, we saw that people's nutrition care plans did not detail their likes or dislikes or preferred portion size. These were on a list in the kitchen instead. There was no information about how someone with dementia could indicate if they were hungry or thirsty, where people preferred to eat or with whom. Another person's care plan regarding activities was also incomplete.

A person had an anxieties care plan in place. This stated that they did get anxious and had medication for this. There was some guidance for staff that if the person's anxiety heightened it was a sign of an infection. However, there was no other guidance about what could cause the person to become anxious and how staff could help with this. There was no information about any other emotional needs or what made the person happy. An entry in the person's care plan stated 'they were very nasty this morning, refused any personal care and wouldn't let me re-pad them at lunchtime' This entry demonstrated that the staff member did not understand what had caused the person's frustration or what techniques were used in response to it.

Another person had medication when required to help alleviate agitation. The registered manager confirmed it was given when the person became agitated. However the person's care plan for anxieties stated 'Does not display any anxieties – they often call out at night but only for reassurance or to go to the toilet'. This meant there was not guidance for staff to follow if the person became agitated.

Care plans contained some information about people's background and life history but this information was not very detailed. Experienced staff we spoke with were able to demonstrate they knew people well and were aware of their preferences. This information was not in people's care plans but learned over time through getting to know people.

The management team carried out monthly reviews for people and a more in depth annual assessment for each area of people's needs. Some of these reviews identified some changes; however, they were not

always reflective of people's current needs. For example, on one person's communication annual assessment care plan it was documented that '(Name) is not able to communicate their needs, staff are to pre-empt their needs'. However, we observed that this person asked a staff member at lunch for a particular item of food which they got for them.

Another person had a mobility assessment in place which stated 'Zimmer and 2 carers, unable to walk'. However, we observed this person walking with their zimmer frame. When we discussed this with the registered manager they told us they must have missed this when they updated the care plan.

On another person's communication annual assessment care plan it stated 'DoLs???????' This did not provide any guidance on how the person could be supported with their communication needs or how their communication needs had changed.

Some people, who were living with dementia, were unable to tell staff when they were in pain. Indicators of pain were not included within their care plans to help staff identify when pain relief might be needed. A pain assessment tool was not being used to enable staff to assess the level of people's pain and the effectiveness of any pain relief that was given. The registered manager told us they had ordered some pain assessment tools and they would begin to use them once they had arrived.

Some daily activities were task led by staff. For example, a member of staff told us there was a bath list in place. They went on to tell us that people had baths on certain days depending on what room number they were. Another staff member told us that only three members of staff bathed people and a third said "We have set ladies who do the baths'. When we asked what would happen if someone wanted a bath on a different day, the staff members told us they would do this, however they went on to say that this had not happened.

There was a risk of people not receiving person centred care, because the information was not available to guide staff on how to provide appropriate care that met people's needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On one person's care plan it stated what to do if a person was reluctant to take their medication. A member of staff followed this guidance and the person was then happy to take their prescribed medication. On another person's communication care plan it was documented that the person did not want to wear their hearing aids and was hard of hearing, therefore staff should write down things for them. This was evidenced during the inspection and worked well for the person.

There was a complaints procedure in place and this was clearly displayed in the lift and entrance foyer. We asked people if they felt able to complain if need be, one person told us "I've got no complaint to make, we have meetings now and then and I can express my needs and concerns" and another person said "They usually look into it and they do something about it".

We saw the home had a complaints file and there was documentation about one complaint. The home had sought the assistance of the local authority to help resolve the complaint. However, the complaint was not resolved satisfactorily and the relative who made the complaint was unhappy with the way it was handled by the home. They went on to move their relative to another home.

We saw that the complaint in the file had been investigated; however there was no evidence of learning applied to the practice in the service as the provider felt they did not need to make improvements.

The failure to take proportionate action in response to complaints was breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were asked for their views, including during monthly 'residents' meetings and staff responded to these where possible.

We asked people about the activities in the home. One person told us "We never seem bothered, we are quite happy", while another said "Oh yes, films, making us laugh, we are not miserable here" and a third said "There are activities, music up there, I enjoy TV".

The registered manager and activity coordinator told us there were a wide variety of activities in the home which included music for health, craft, flower arranging and quizzes. There were also summer and Christmas fairs.

On the first day of inspection we did not see any activities happening in the home. People either spent their time in their rooms or in the lounge area. The television was on for most of the day in the lounge area; however, we noted that people were not often watching it. During lunch a member of staff put some cheerful music on which was enjoyed by people. One person's demeanour visibly changed and they were humming and tapping their feet in time to the music.

On the second day of inspection we saw that 11 people were taking part in a musical activity. People were clearly enjoying this. For the remainder of the day people either spent time in their rooms or in the lounge again. Although we observed a limited amount of activity in the home, people mostly appeared relaxed and content.

We observed that some people spent the majority of time in their rooms. The activity coordinator told us they spent time with people individually in their rooms and chatted with them, read or gave hand massages. However, due to a lack of documentation, it could not be evidenced how much stimulation and occupation was available for these people.

We discussed how the use of technology including IPads could be beneficial for people living in the home and on the second day we saw an IPad was being used as part of one to one activities with people.

The registered manger told us people from the church came into the home. We asked people whether their spiritual needs were met in the home. All of the people we spoke with told us that they were not. They said there was not a religious service that regularly took place in the home. One person told us "There's nothing in here, but you can go to the church nearby, 5 minutes' walk from here".

The registered manager told us that people usually stayed at The Haven when they were at the end of their life. The registered manager and staff told us that they received support from GPs and nurses in relation to end of life care. They also told us that they ensured the necessary equipment was in place. There was very limited information in people's care plans about their end of life wishes. This meant that staff would have been unable to identify how people wished to be cared for at the end of their life.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection we found The Haven required improvement. At this inspection we found the level of service provided had deteriorated. At this inspection we identified eight breaches of regulations. Following our last inspection, the provider sent us written information about how they would improve the service. They had ensured that the issue previously identified with medication had been rectified. However, other areas were not compliant with the regulations.

We had identified a breach under Regulation 17 as systems and processes did not ensure the provider was able to assess and monitor the quality of the service and mitigate the risks relating to the health, safety and welfare of people using the service. At this inspection visit we continued to find a breach of Regulation 17 Good Governance.

The provider used a list which was set out on an annual basis. This included the areas that the management team needed to monitor and assess. However, this was not effective and did not address the concerns we identified at our inspection or demonstrate what remedial action had been taken. Shortfalls in relation to managing risks for people, inappropriate consent, the cleanliness of the home, providing person centred care and poor record keeping had not been identified by the provider.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. Care plans had been reviewed monthly, but the reviews had not ensured that these were reflective of people's current needs.

There was a lack of effective and proactive analysis of accidents and incidents in the home. Incidents such as falls, behaviour that challenged, injury and safeguarding incidents had not been analysed, therefore trends and patterns could not be identified and there were no records to support what action had been taken to minimise further incidents or to keep people safe.

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.

All services registered with the Care Quality Commission (CQC) must notify the CQC about certain changes, events and incidents affecting their service or the people who use it. We use this information to monitor the service and to check how events have been handled. The local authority had told us about two allegations of abuse but these had not been notified to us. Additionally, one person had sustained a serious injury and this was not notified to the CQC. Furthermore, on the second day of inspection we saw that the boiler had broken a week before meaning it could not provide hot water or heating. This had not been reported to the CQC. We had seen from people's financial records that seven people had died in the last seven months but we had only received a notification for three of these. When we discussed the failure to send notifications, the registered manager told us they did not know they always had to. This meant that the CQC had been

unable to monitor the concerns and consider any follow up action that may have been required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We asked people about how the management team supported them. One person told us "If we are not happy, we talk to them and they do listen". Another person said "Oh yeah they are very good" and a third said "Do they come and find out how we are? Not really".

Two relatives told us that they did not know who the registered manager was but they were happy with the care that their loved ones received. One relative said "I have my mind at rest, mum is happy and content" and another said "Everybody is friendly, attentive, mum is in a safe environment and she is very well looked after".

All staff were complimentary about the management team. Staff described the registered manager as 'really nice', 'approachable' and 'brilliant'.

Health professionals had mixed views about the service. A bank nurse told us they didn't visit the service often but found the staff helpful and that they followed instructions. However, the manager of the district nursing team told us they had concerns about the home's management of a recent incident. The local authority informed us that they had just started to carry out a large scale enquiry regarding the home's ability to provide safe and effective care for people. This meant they would be closely monitoring the service provided to people at the home. This enquiry resulted in the home making improvements and the local authority told us they would conclude the enquiry and go on to monitor the home on a less frequent basis.

The home was managed by the registered manager, the business manager and the provider; the registered manager told us that they each had their own responsibilities in regard to running the home. We found the registered manager did not always have oversight of what was happening in the home on a day to day basis. For example, when we asked the registered manager if any of the people in the home had a high 'MUST' score, they told us they did not. They later told us the business manager dealt with this so they were unsure. We then established that 'MUST' scores were not being done at all. 'MUST' is a screening tool to identify people who are risk of malnutrition and includes guidelines which can be used to develop a care plan. The registered manager was also unaware of other areas of the home such as some people's care needs, people's finances, a health and safety issue and an issue with medication.

People told us the provider was in the home frequently and knew them. However, there were no quality checks in relation to the safe and effective running of the home which had been undertaken by them.

Supervisions and appraisals were carried out with staff but staff were not always monitored effectively. A social care professional told us when they visited or rang the home the registered manager was not there but came in after a phone call home. When we carried out our inspection the registered manager was not there on our arrival but came in soon after. The registered manger told us they were in the home frequently but this was not recorded on the rota. When we asked one member of staff what the best thing about working in the home was, they told us, "I'm my own boss, there's no one breathing down my neck". There was also an instance where night staff had invited people who did not work in the home for a social gathering and posted a photograph on social media. The registered manager told us they were surprised by this but did not check on the home during the night.

All the staff expressed commitment to the people living at The Haven. They used comments such as "the best thing about this home are the residents, I just love them" "They're lovely". Staff were also

complimentary of each other. They said "We're a good team" "The team is good"" and "It's friendly here". We asked six members of staff what could be improved in the home and four could not think of anything, one staff member told us they thought some new chairs would be beneficial and the other thought another member of staff in the evenings would help. All staff members told us they enjoyed working at the home.

The provider engaged people, their representatives and staff in the running of the service and invited feedback through the use of questionnaire surveys. Feedback was predominantly positive, however there was no evidence that this had been used for learning and development of the service.

The previous CQC rating was prominently displayed in the entrance hall to the home and on the provider's website.

The provider had sought the expertise of an external consultant to carry out an audit of the home, however this did not identify the concerns that we found during our inspection.

The registered manager told us they had very recently purchased a management system to aid them in the effective running of the home. The registered manager told us that they were committed to the home and wanted to see it succeed. We had discussed some of our concerns with the registered manager on the first day of inspection and we noted on the second day of inspection they had started to make improvements, these included the use of assessment tools, guidance for staff in relation to medicines and a programme of refurbishment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify the commission without delay of relevant incidents. Regulation 18(1)

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to assess, plan and provide care and treatment to meet people's needs and preferences Regulation 9 (1)(3)(a).

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to protect people's privacy and dignity at all times. Regulation 10 (1).

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to ensure people only receive care and treatment with the consent of the relevant person. Regulation 11 (1)(2)

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure risks relating to the safety and welfare of people using the services are assessed and managed. The failure to fully protect people from the risks associated with the unsafe management of medicines Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The failure to ensure the premises were clean and free from odour. Regulation 15 (1) (a)

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The failure to act proportionately on complaints. Regulation 16 (1) (2)

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A failure to have effective systems and processes in place to drive continuous improvements, to assess, monitor and mitigate risks relating to the health and safety of people, and the failure to

maintain an accurate, complete record in respect of each service user. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

We imposed conditions on the provider requiring them to submit an action plan and details of newly updated documentation to the Care Quality Commission on the first day of every month.