Care Homes UK Ltd

Haven Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 January 2016 and was unannounced. We returned again on 20 January 2016 and this was announced. The service had previously been inspected in June 2015 and this had identified five breaches in the Health and Social Care Act 2008 (Regulated Activities) regulations at that time. We found at this inspection the provider had taken all necessary actions to improve the quality of care.

Haven Lodge is registered to provide accommodation and personal care for up to 32 people. There were 32 people living at Haven Lodge at the time of our inspection.

Accommodation at the home is provided over two floors, which can be accessed via stairs or a stair lift.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The home provided a friendly, welcoming environment for people. Some parts of the home were in need of maintenance, such as the ceiling in the lounge that was damaged in recent weather, and bedroom furniture that was worn. The registered manager was aware of the improvements that were required.

People told us they felt safe and staff demonstrated safe practice. Staff understood how to ensure people were safeguarded against the risks of abuse.

People who needed assistance to mobilise were supported safely, although their moving and handling plans were not always sufficiently detailed.

Medicines were managed safely and people received their medicines on time.

The home was clean and there were no malodours. Staff understood how to prevent the spread of infection, although procedures for emptying and disinfecting commodes were not always suitable.

Staff were well supported to carry out their roles and had suitable opportunities to update their skills and professional development.

Staff had a secure understanding of the impact of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People enjoyed the meals, snacks and drinks. People's dietary needs were catered for appropriately, although some people said they were not always offered a drink upon waking first thing and had to wait for breakfast.

People's dignity and rights were promoted well and they were treated respectfully. There were good relationships between staff and people living in the home and staff were kind and patient in their approach.

People said they felt included and involved and there was evidence of person centred care; people said their care was how they wanted it to be.

Care records were up to date, although where people's needs had changed it was not always evident they had been referred to other professionals, such as for specialist seating assessments.

People and relatives we spoke with understood the complaints procedure and said staff and managers were approachable for them to raise any matters for discussion. Complaints had been responded to appropriately.

There was evidence of effective teamwork and everyone we spoke with said they felt the home was well run. Communication was clear so all staff understood people's needs. Systems and processes to underpin the safe running of the home were in place. Areas in need of improvement were identified, such as premises/equipment refurbishment, and there were action plans in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were supportive of people's needs.

Staff demonstrated safe practice and they were confident in their knowledge of how to ensure people were safeguarded against possible abuse.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were given choices in the way they lived their lives and their consent was sought in line with legislation and guidance. Staff had a sound understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff had access to relevant training to enhance their role. Staff had regular supervision meetings to support them in caring for people's needs.

Staff worked with other professionals, such as GPs and district nurses, to support people's health needs.

Is the service caring?

Good

The service was caring.

There was evidence of good relationships between staff and the people who lived at Haven Lodge. Staff were kind, patient and respectful in their approach.

Staff took time to actively listen to people and valued their point of view.

People's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive.

People's individual preferences were considered and there was good evidence of person centred care.

People's individual care records showed information was up to date for staff to provide personalised care. Moving and handling and emergency evacuation plans needed more precise detail, although staff had a clear knowledge of people's individual needs.

People and their relatives had access to information about how to raise concerns and give feedback about the service.

Is the service well-led?

Good

The service was well led.

The registered manager was supported by managers within the wider organisation, was visible in the service and knew the needs of the people in the home. When the registered manager was absent, staff were clear about who was in charge and the home was run well.

Systems were in place within the organisation to regularly monitor and review the quality of the service.

Audits identified where improvement was needed and action plans had been raised to address these.

Haven Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 12 January 2016 and was unannounced. The registered manager was unexpectedly absent on that day so we returned, announced to speak with the registered manager and complete our inspection on 20 January 2016.

There were two adult social care inspectors on 12 January 2016 and one adult social care inspector on 20 January 2016. Prior to our inspection we reviewed information from notifications. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We liaised with the local authority commissioners and safeguarding teams before the inspection. We spoke with 12 people who used the service and four relatives during our visit. We spoke with the registered manager, and four staff. We observed how people were cared for, inspected the premises and reviewed care records for six people. We also reviewed documentation to show how the service was run.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said: "Put it this way, I am far safer here than if I was on my own" and another said : "Course I'm safe, there's always someone about to see if I'm alright and that's comforting ". We spoke with one person who was being assisted to use the stair lift and they told us: "I feel safe using this stair lift and I feel safe with her [staff member]".People's relatives we spoke with said they felt their family members were safely cared for. One relative said: "[My family member's] safety is my main concern and I have peace of mind that they're living here" and another said: "Yes, very safe here". One relative whose family member was new to the home highlighted safety as one of the main quality features.

Staff were confident in their knowledge of the signs of possible abuse and they described the process they would follow to ensure people were protected from harm. Where a person's behaviour might challenge the service or other people, staff knew how to respond in order for all people to feel safe living in the home. Staff said they felt confident to challenge poor practice if they saw this and they knew the whistleblowing procedure to follow to ensure people were safeguarded. The registered manager told us she would always support staff to follow the whistleblowing procedure.

People's individual risk assessments were up to date within their personal care files, although risk assessments for moving and handling lacked specific detail regarding equipment that was needed. Personal evacuation plans also did not highlight any necessary equipment. Staff we spoke with knew how people should be assisted safely, but this was not documented in enough detail should unfamiliar staff need to know. The registered manager said there were always familiar staff in post and agency staff were not used, but agreed to address this. People we spoke with told us staff gave support for them to be as independent as possible. We saw staff assisted people at their individual pace and patiently enabled people to do things for themselves, such as walking from room to room.

We saw staff involved people in discussions about their personal safety in relation to their care and the environment. Staff asked people whether they needed support, such as assistance with sitting down, getting up or getting dressed.

The registered manager told us there were robust procedures for recruitment. We scrutinised five staff files which demonstrated the provider was employing effective staff recruitment and selection systems. We saw there was a clear process which ensured appropriate checks such as, proof of identity, references and satisfactory outcomes of Disclosure and Barring Service (DBS) were carried out before staff began work. These checks helped the service to make sure job applicants were suitable to work with vulnerable people. We saw the manager had secured identification in the form of either a driving licence or passport. Where staff required a visa to allow them to legally work in the UK the manager had retained a copy of the visa in the file.

We saw staffing levels were appropriate to provide care and support for people. We saw staff spent time engaging in meaningful conversation with people as well as helping them manage their physical care needs. People told us they thought there usually were enough staff and they said staff were attentive if they needed

help and support. However, we spoke with one person who told us they had to wait 'longer than usual' to get dressed because there were not enough staff. They said this was 'quite unusual'. We spoke with staff about this and we were told the registered manager had covered a night shift as there had been an unexpected staff absence.

We saw accidents and incidents were recorded appropriately and there was detailed analysis of these to establish whether there were any trends or patterns.

Medicines were administered to people by trained care staff. We were told people were assessed as to their capability to self-medicate. Whilst no people had been found capable of self-medication the process demonstrated the provider was attempting to maximise people's independence.

We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete. The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We conducted a sample audit of seven medicines dispensed in boxes to check their quantity. We found on all occasions the medicines could be accounted for. We found people's medicines were available at the home to administer when they needed them.

Our scrutiny of the MAR sheets and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed.
Arrangements for the administration of 'as necessary' (PRN) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. The care worker who was administering medicines demonstrated a good understanding of the protocol.

We saw evidence people were referred to their doctor when issues relating to their medication arose. Allergies or known drug reactions were clearly recorded on each person's MAR sheets.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register. All medicines recorded in the register were accurately accounted for. We found two boxes of medication which had not been entered into the controlled medicines register. The deputy manager who had responsibility for managing medicines told us they had obtained recent clarification from the pharmacy that this was not a controlled drug and we saw the symbol on the drug packaging stated this was not a controlled drug.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. The application of creams was recorded on a separate topical medicine administration record containing a body map showing the areas where the cream had to be applied.

We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The medicine trolley was located in a locked room when not in use. Drug refrigerator and storage temperatures were checked and recorded to ensure medicines were being stored at the required temperatures.

One person had their medicines administered covertly. An examination of the person's care records demonstrated correct procedures had been applied to ensure the medicines were administered within current guidelines. We saw meetings had occurred involving the GP, family members, and care staff with personal knowledge of the individual. Whilst we saw a pharmacist had current knowledge of the medicines being administered covertly we could not find evidence they had been involved in the best interest meeting. Documents demonstrated a clear treatment aim of covert medication along with the desired benefits to the person's health. A list of all medicines to be administered covertly was recorded in the care plan. A qualified person had made a written statement regarding the person's lack of capacity, specifically with regard to medication. Whilst care planning reviews were a common feature of the service we could find no evidence of a specific review of the practice of covert medication with the involvement of the original decision makers. We recommend the provider considers current guidance on giving people covert medicines and take action to update their practice accordingly.

We noticed the environment was clean and there were regular routines in place for maintenance and repairs. Communal areas were tidy and there was a maintenance staff member checking and replacing light bulbs during the inspection. We saw the ceiling in the lounge area had a large hole in and part of the lounge was inaccessible to people. The registered manager told us this was caused as a result of a winter storm the week of the inspection and there were plans in place to repair this within a short timescale. People we spoke with told us they had temporarily moved seats until the repair was carried out. Some aspects of the environment, although safe, were in need of refurbishment. For example, cupboard units in bedrooms were worn. We saw there were no bedside tables in some of the bedrooms for people to put items they required close to hand, such as a drink. The registered manager told us there were plans to address these as part of a rolling programme.

Staff were seen to pay close attention to hand washing hygiene throughout our visit and they used personal protective equipment (PPE) appropriately. Staff told us PPE was always in plentiful supply and easily accessible to them. We observed when staff emptied the commode pans upstairs, this was done within the toilet in the communal bathroom and there was no disinfectant used to clean these. We discussed this with the registered manager who agreed the facilities were not adequate as there was no available sluice, and they agreed to review this with immediate effect. People and relatives told us they always found the home to be clean and said there were no malodours. One relative told us: "I'm very happy with the cleanliness in this home".

Good

Is the service effective?

Our findings

People told us they thought staff knew how to do their jobs. One person said: "They are lovely to me, I'd be lost without them [staff]". Another person said: "I know they do things right for me". Relatives we spoke with said they were confident in staff abilities.

Staff said they felt supported to undertake their work. We found staff shared responsibilities for people's care and communicated well to meet people's needs.

The registered manager said staff had regular supervision and we saw evidence of supervision meetings recorded. Staff told us they attended staff meetings. Staff we spoke with told us they had frequent opportunities to undertake training and development and keep up to date with new information.

Our review of staff records showed staff had received recent training in a range of areas including; safeguarding, dementia awareness, manual handling, food safety, fire safety, first aid and infection control and prevention. Scrutiny of five staff records confirmed regular supervision meetings were a feature of the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

We saw five standard authorisations had been submitted to the supervisory body for current residents. Three authorisations were in place, two of which had attached conditions. We saw from care plans the conditions were being complied with. Two authorisations were still with the supervisory body awaiting a decision.

We saw where issues around lasting powers of attorney required consideration in care planning this was clearly noted in the care file. We saw evidence from the Office of the Public Guardian detailing named attorneys. Care plans showed the provider was ensuring inclusive consent procedures were followed in determining people's care needs.

We spoke with the person in charge about the use of restraint which included the use of bed-rails. We saw one person had bed-rails in place. Review of the person's care plans demonstrated a risk assessment had been completed prior to the use of bed-rails. The risk assessment showed the person was at risk of rolling

out of bed and the use of the bed-rail was to protect the person from harm. The care worker we spoke with had a clear understanding of how bed-rails should not be used to confine people to bed and as such would constitute illegal restraint.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by qualified clinicians. There was evidence of involving family members in these decisions. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

Staff demonstrated a good understanding of the need to gain people's consent for care and support and this was evident throughout the inspection. For example, staff asked people before assisting them with any aspect of their care and people's privacy and dignity was maintained well through discreet interaction. Staff we spoke with told us where people could not communicate verbally they used non-verbal cues to establish consent. For example, staff said they used gestures and observed facial expressions to help understand and interpret people's choices.

People we spoke with told us staff always gave them choices and asked their consent for aspects of their care and support they needed help with.

We observed lunch time in the home. Tables were suitably set and people chose where to sit. Where people chose to eat their meals in their rooms, we saw staff supported them on an individual basis according to their needs and wishes.

We saw the menu was displayed on the whiteboard in words and pictures. We noted however that although people were offered a choice of meal, this was served in portions determined by staff with no discussion with people about their preferred component parts of the meal. Staff offered people choices of drinks.

Staff told us which people were being monitored for food and fluid intake and we saw records for these people. Staff were observant of people who had little appetite and encouraged them to eat and drink to support their health. We saw people were offered drinks at regular intervals, including for those people who chose to stay in their rooms and staff patiently assisted people who needed support. One person complained their meal was cold and staff checked and found this was still hot, but offered to bring them a replacement meal.

Many people told us they enjoyed the food. Comments included: "I love the food here", "I eat plenty here", and "It's not bad, there's always something I like".

On our arrival the first day, two people said they had not had a drink since waking and had to wait until breakfast. We asked staff who told us people had all been offered a drink,

We spoke with the cook, who explained how the menus were varied and nutritionally balanced. Where dieticians were involved, care staff kept the cook informed of any special requirements. The cook told us where people had special dietary requirements there was plenty of choice available. They explained how they fortified meals where people needed extra calories and staff kept them informed about people's individual requirements.

The service worked closely with a range of health professionals Staff we spoke with told us if they were concerned about a person's health they would report this to the registered manager and make sure the person had access to appropriate medical advice and support, such as their GP.

We saw when one person was feeling unwell, staff promptly arranged a GP visit.

We saw the communication book showed clear evidence of staff contacting other professionals where necessary, such as GPs and dieticians and people's health appointments were noted in the diary.

Good

Is the service caring?

Our findings

People told us they were happy and well cared for. One person said: "They love me and I love them. I wouldn't be without them", then to staff they said: "I love you" to which staff responded with smiles. Another person said: "We care about each other in this place". Another person said: "I look out for the others and that helps staff. The staff care about us, that's why they do this job so I try to be an extra pair of eyes and watch to see people are alright".

We found the home was welcoming with a friendly atmosphere. Staff demonstrated a kind and caring approach with all of the people. We saw staff involved people and actively listened to what people had to say, taking time in conversation so people felt valued and important. Staff used friendly facial expressions, calm tones of voice and positive body language when communicating with people. There was appropriate use of banter and we heard people laughing and chatting with staff.

Staff we spoke with were knowledgeable about people's individual needs and their social histories. These were also recorded in detail on people's care records for staff to be able to consider each individual's diverse needs. Staff spoke with people about the things that were important, such as which family members were coming to see them.

Where people chose to get up later in the morning, staff respected their wishes and when they were ready to start their day, staff offered caring conversation, such as by asking people what sort of a night they had had and enabling them to get ready at their own pace.

We saw staff were observant of people's needs. For example, one person looked unwell and staff discreetly assisted them to their room, offering reassurance and support for their privacy and dignity. Where staff assisted people with personal care this was done in such a respectful and sensitive way.

Where people remained in bed, staff took time to listen to what they said and find out what they would like. For example, staff told us one person was receiving care in bed at the end stage of their life and we saw staff made every effort to listen to this person, even though it was difficult to hear the person's voice. Staff understood the person's request for a pint of bitter and promptly went to bring this for them, which they thoroughly enjoyed with assistance to drink it. Where people were new to the home or where they appeared disorientated or confused staff offered reassurance and explanations to help them feel settled.

We saw in the care records we looked at that some information was recorded in relation to people's end of life so that their individual personal wishes for care could be considered.

Good

Is the service responsive?

Our findings

People we spoke with said the care provided was responsive to their individual needs. People said they could choose when to get up and when to go to bed, or when to have a bath or shower. One person told us: "If I fancy a bath I just let them [staff] know and they help me". Another person told us: "I usually get up early but not today, I fancied a lie in and they [staff] didn't disturb me".

People's own rooms were personalised with their belongings and familiar photographs which created a homely feel. We saw people had access to call bells in their rooms and staff knew which people were unable to operate these and made routine and planned checks. Staff were attentive to those people who were in bed and made frequent additional checks on people's well-being. Where people remained in bed, staff completed pressure care charts and ensured people were supported to change their position. People were not always able to reach drinks within their rooms because not all people had a bedside table. The registered manager said she would address this with immediate effect.

We looked at six people's care records and these contained up to date information. Where other professionals had involvement in people's care this was documented. People's individual care plans were in place and person centred and staff told us how they referred to these and updated them with new information.

Care plans and risk assessments were regularly reviewed and information in the records we looked at mostly reflected people's needs, although for one person who appeared to have awkward seating posture staff told us their physical needs had gradually changed but there had been no referral to other professionals for a seating assessment. We discussed this with the registered manager who assured us this would be done the same day. Information in care records was easy to locate and there was evidence of regular reviews of people's care in the care files we saw.

Staff told us they had handover discussions between shifts and they used the communication book to share key information. Staff we spoke with said they felt informed about what had taken place the previous shift for them to respond effectively to people's needs.

There was a friendly atmosphere in the home and people enjoyed a range of activities. We saw the activities coordinator organised small group board games and people enjoyed the social contact as well as the game. People told us they were 'looking forward to a sing song' and we saw there was a singing session which people were involved in and enjoyed.

People told us they felt their rights were respected. People told us if they wished to complain about anything they would speak with the staff. The people we spoke with said they did not have any cause for complaint but they felt staff would listen and help them with any concerns. Relatives we spoke with said they felt involved in their family members' care and informed about how the home was run. They said should they need to complain they would readily approach any member of staff or the manager.

We saw the record of complaints and compliments and discussed these with the registered manager who told us how these were managed and reviewed by the organisation. Relatives' and family meetings were held and there was a poster on the noticeboard which gave information about the forthcoming one.

Good

Is the service well-led?

Our findings

People we spoke with and their relatives all knew who was in charge of the home and considered the home was well run. They told us, and we saw, the registered manager was fully involved and visible in the service. We found the registered manager had been supported consistently by the staff team and the operations manager.

Staff told us they felt confident in their roles and responsibilities. Staff understood who was in charge in the absence of the manager and we saw this was effectively implemented during day one of the inspection. The registered manager and deputy manager were not present and the senior care assistant managed the running of the home, with clear knowledge of systems and processes in place. Staff told us they felt happy and motivated in their work and were supported well by the registered manager who was approachable. Staff reported good morale throughout the home and an open transparent culture.

We saw there were measures in place for assessing and monitoring the quality of the service provision. For example, the registered manager told us she gained oversight of staff practice through being present and involved in the daily routine, as well as regular walk rounds within the home. Records of regular audits were available for inspection and where these highlighted actions that needed to be taken, action plans were in place with timescales. The registered manager told us analysis of information took place to ensure information was meaningful and lessons were learned, such as with accidents and incidents. Maintenance records for the premises and equipment were organised and available for inspection.

Policies and procedures in the home were updated and staff signed to show they had read these. Staff we spoke with knew what to do in the event of an emergency such as a fire evacuation. Information given to us by staff regarding the running of the home was reflected in the policies and procedures we looked at.

Information confidential to people was stored securely within files in the office and no personal information was on view within the home. However, we found there were some archived boxes of care records stored within an unused wardrobe in one person's upstairs room and we discussed this with the manager who said this was being addressed and these would be relocated to a more appropriate area. The registered manager told us she was satisfied the person would be unable to access this wardrobe themselves, although acknowledged this had been identified as in need of more secure storage.

Feedback about the standard of care was sought from people, relatives and visitors. Where surveys were completed the results were displayed for people to see in a 'you said, we did' format to show people's views had been taken seriously. Relatives we spoke with said they were frequently asked their opinions about the quality of the service provision and they were confident their suggestions were considered.

The registered manager was responsive to the inspection process and had addressed the issues raised at the previous inspection. She told us she was committed to driving improvement and described some of the ways in which this could be achieved. For example, there were plans to establish champions within the staff team, such as for end of life care and dementia care.