Key inspection report

CARE HOMES FOR OLDER PEOPLE

Havencroft Nursing Home

Lea End Lane
Hopwood
Birmingham
West Midlands
B48 7AS

Lead Inspector
Chris Potter

Key Unannounced Inspection
10th September 2009 09:00

This report is a review of the quality of outcomes that people experience in this care home. We believe high quality care should:

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care homes for older people can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop.

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

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SERVICE INFORMATION

Name of service	Havencroft Nursing Home
Address	Lea End Lane Hopwood Birmingham West Midlands B48 7AS
Telephone number	0121 445 2154
Fax number	0121 445 2159
Email address	
Provider Web address	
Name of registered provider(s)/company (if applicable)	Regal Care Limited
Name of registered manager (if applicable)	Lesley Ann Owen
Type of registration	Care Home
No. of places registered (if applicable)	32
Category(ies) of registration, with number of places	Old age, not falling within any other category (32), Physical disability (32)

SERVICE INFORMATION

Conditions of registration:

1. The registered person may provide the following category of service only:

   Care Home with Nursing (Code N)

   To service users of the following gender:

   Either

   Whose primary care needs on admission to the home are within the following categories:

   Old age, not falling within any other category (OP) 32
   Physical disability (PD) 32
2. The maximum number of service users who can be accommodated is: 32

Date of last inspection 8th September 2008

Brief Description of the Service:

Havencroft Nursing Home is a large, Victorian building. It is located just off the main road in the village of Hopwood. Hopwood is close to the boundary of Birmingham easily accessible from junction two of the M42 motorway. A limited bus service which stops within walking distance of the home is available for visitors. Limited off road car parking is available outside the home for staff and visitors.

The home is registered to provide nursing care for up to 32 people who require 24 hour nursing and personal care. The home is equipped with specialist equipment to assist the staff in meeting the health and personal care of the residents. This includes a range of pressure-relieving mattresses to help prevent the development of pressure ulcers, and mobile hoists to help people move from (for example) their bed to their wheelchair if they have limited or restricted mobility.

Accommodation is provided on three floors in both single and shared rooms. A lift is available to assist people using the service to access all areas of the home. Communal areas are available with three lounges and a separate dining area, so that the residents have a choice of where they wish to spend their day. Specialist bathing facilities are provided on each floor so that people with limited mobility can receive support with their personal hygiene needs. A large

garden is available for the people to use when the weather permits. A limited range of activities are provided for the people.

The registered providers are Regal Care Limited, and the registered manager for the home is Lesley Owen, who is a first level registered nurse with many years experience working in both the National Health Service and the private sector.

Information regarding the home can be obtained from the statement of purpose and the service users' guide which are available from the home.

Information regarding fees for the Home should be requested direct from the manager or from the owners.

Copies of the most recent Care Quality Commission inspection report are readily available within the Home and on request.

SUMMARY

This is an overview of what the inspector found during the inspection.

The quality rating for this service is **0 star**. This means the people who use this service experience poor quality outcomes.

This was a full inspection of Havencroft nursing home where we look at how the Home is performing in respect of the core national minimum standards (the report says which these standards are) and the quality of the service that the people who live there experience. We call this type of inspection a key inspection.

We, the Commission, made three visits to the Home for this inspection; this included a pharmacist who visited on the 03/09/09, and two inspectors who arrived unannounced on the 10/09/09 and 14/09/09. One inspector carried out an observational assessment as part of the inspection. This is where we sit with people to see how people pass their time and how much contact they have with staff.

The Home completed an Annual Quality Assurance Assessment and we used information provided in this to help us plan our inspection. We also took into account information in surveys that were returned to us by six people who live in the Home (some of these were filled in for them by relatives), and four staff members.

During the inspection we spoke to people who live in the Home and to the relatives of two people.
We also spoke with the manager, nurse in charge and deputy manager during the visits.

We inspected parts of the premises and looked at various records such as care records and staff files.

On the 10/09/09 it was apparent that there were insufficient staff on duty for the size and layout of the home, and for the number and dependency, health and welfare needs of people living there. An immediate requirement notice was issued for the home to ensure that sufficient staff are available throughout the 24 hour period who possess the necessary skills and competencies to ensure that the health, welfare and social needs of the people using the service are safely and effectively met. We contacted the registered provider to report our concerns and it was agreed that additional staff would be allocated.

What the service does well:

Havencroft Nursing home provide people with sufficient information about the home in the form of a Service User Guide to assist them making up their minds about the home.

People are provided with a contract of terms and conditions on admission to the home which helps them to understand their rights.

Havencroft have a good training plan in place for the carers and above 50% of care staff have completed the NVQ level 2 in care qualification which assists in helping them understand the needs of the people living in the home.

People living in the home are encouraged to take in personal possessions to provide a more familiar environment.

The home provides a varied menu for people living there. Comments received from people using the service *'the quality of food is excellent'*

Visitors are made welcome in the home and are able to see people in the privacy of their room.

The home employs male and female staff from a multi-cultural background.

What has improved since the last inspection?

From reviewing the information we received prior to the inspection and visiting the home for the key inspection, we found that the service has failed to demonstrate any improvement since the last key inspection which was completed in September 2008.

What they could do better:

Issues around medication were found during the inspection. The home must ensure that people receive their prescribed medication correctly. The storage of medication must be safe to protect people using the service.

Staffing arrangements need to be reviewed to ensure that staff are always deployed effectively and in sufficient numbers so that people in the home have the individual care and attention they need.

The home needs to work on improving the quality of written plans describing people's care needs to make sure the plans give clear information and guidance to staff and reflect each person's needs and wishes.

The health and social care needs of the people who use the service need to be promoted and staff need to act upon outcomes of assessments and instructions from health professionals to ensure people are not placed at risk of harm through neglect of care.

Improvement is needed to the storage and management of medication to ensure medicines are being stored safely and securely and they do not deteriorate which can make the medication ineffective and possibly harmful to the people who use the service.

Having observed a person having an unfinished drink removed from them and a second placed in front of them which was left to go cold, the person was left in a wheelchair at the dining room table in excess of two hours. Staff need to be reminded of how important it is to always have people's dignity and rights at the heart of everything they do.

If the Home is going to continue to accommodate people with dementia type illnesses they need to find out more about recognised best practice in this area of care, including care practice, communication, training and how the environment can be used to help people.

Several incidents occurring to people were caused by the lifting equipment, which may mean that staff are not using the equipment correctly, or they are in a rush with the person. To further protect people living in the home all accidents should be reviewed and investigated, while significant events should be reported to the Care Quality Commission under Regulation 37.

The hours allocated for cleaning should be reviewed to ensure that the staff have sufficient time to clean and maintain a good standard for the people living in the home.

The outlook from the lounge is poor for the people living there due to the uncompleted building work and the overgrowth of weeds.

The standard of decoration, and floor coverings should be reviewed to provide the people living in the home a pleasant environment.

To further protect people living in the home all staff recruited should follow the correct procedure and safety checks.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk. You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line – 0870 240 7535.

DETAILS OF INSPECTOR FINDINGS

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Choice of Home

The intended outcomes for Standards 1 – 6 are:

1. Prospective service users have the information they need to make an informed choice about where to live.
2. Each service user has a written contract/ statement of terms and conditions with the home.
3. No service user moves into the home without having had his/her needs assessed and been assured that these will be met.
4. Service users and their representatives know that the home they enter will meet their needs.
5. Prospective service users and their relatives and friends have an opportunity to visit and assess the quality, facilities and suitability of the home.
6. Service users assessed and referred solely for intermediate care are helped to maximise their independence and return home.

The Commission considers Standards 3 and 6 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

1,2,3 and 4

People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People are provided with sufficient information about the home before moving in, so that they know what they can expect. Failing to assess people's health and psychological needs accurately may affect the care delivered by not meeting the individuals' assessed needs.

EVIDENCE:

The Annual Quality Assurance Assessment received from the home on the 14/08/09 provided very brief information about how they judged themselves in meeting the standards. Recorded in the section 'what we do well', the home

responded 'care plans and evaluation sheets' which does not relate specifically to the standards in this section.
We received six completed surveys from people using the service, five of which confirmed that people had received sufficient information about the home to assist them with their choice about moving into Havencroft nursing home. One survey stated that they did not know if sufficient information had been provided.

The Statement of Purpose and Service User's Guide were displayed in the reception area of the home. Both documents have been updated this year. The Service User Guide is in easy read format for people to assist in understanding the information. The Statement of Purpose contains copies of the 'Croner' care home guidelines, but these would be difficult for people to understand. It also includes the home's minimal staffing levels that the home would provide. However this was not being adhered to at the time of our visit (see staffing section).

We received confirmation from the surveys that three people had received a contract on admission to the home, and three people stated that they had not. The three care records we reviewed each had a copy of the home's terms and conditions known as the 'contract'.

We looked at the care files for three people as part of case tracking, and the information included in the pre admission assessments. This is an overview of the person to ensure that the home are able to meet the individual's health and personal care needs fully. We were informed by the deputy manager that it is normally the manager who would assess peoples' needs before they were admitted.

It was found that a pre admission assessment had been completed for the three individuals prior to them being admitted to the home. The assessment covered all the basic information needed to assess whether or not the home could meet the individuals needs.

One assessment provided the reason for admission and this included 'diabetic controlled by diet'. However this information had not been included in the person's care plan, so no guidance was available for the staff to follow in how to safely manage this person's condition. No care plan had been developed to manage the person's pain from arthritis.

A copy of a pre admission assessment was seized at the inspection using a regulatory notice known as 'code B'. This was because the assessment had not been fully completed. There were lots of blank pages and spaces, under family and social support. The reason for admission stated 'for nursing care' it assessed the person as having a poor appetite then failed to include information under dietary likes and dislikes. The daily routine recorded 'full nursing care needs assistance with all ADL (activities of daily living)'. Under the

heading 'skin' was recorded 'oedemadous and dry', 'intact'. This person went on to develop a pressure sore, and the date this occurred could not be found from the individual's care records. The assessment had not been signed by the person who completed it.

The pre admission assessments were briefly completed, and failed to include a proper risk assessment for potential development of pressure sores or nutritional risk prior to admission. The information also failed to provide information abpout the person's psychological needs and any issues for them about independence and moving into a nursing home.

Nurses and carers told us that information about the residents was passed on at the end of each shift, but this was in their own time.

Health and Personal Care

The intended outcomes for Standards 7 – 11 are:

7. The service user's health, personal and social care needs are set out in an individual plan of care.
8. Service users' health care needs are fully met.
9. Service users, where appropriate, are responsible for their own medication, and are protected by the home's policies and procedures for dealing with medicines.
10. Service users feel they are treated with respect and their right to privacy is upheld.
11. Service users are assured that at the time of their death, staff will treat them and their family with care, sensitivity and respect.

The Commission considers Standards 7, 8, 9 and 10 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

7,8,9,10 and 11

People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The lack of information in peoples' care records may result in people's health and personal care needs not being met consistently. The home supports people with their medication, but nurses failing to follow the policy could result in errors with the individuals' medication.

EVIDENCE:

The pharmacist inspector visited the home on 3rd September 2009 to check the management and control of medicines within the service.

We found that medication storage was not secure at all times. For example, we saw that the treatment room door could not be locked. The manager

informed us that this would be mended as soon as possible. The means that medication was not kept safe and secure to protect people from harm.

We found that medication was stored within the correct temperature ranges. The temperature of the room was recorded daily at around 24 degrees centigrade. Medication requiring cool storage was seen stored inside a medication refrigerator. The daily temperature of the refrigerator was recorded between 2 to 8 degrees centigrade which is the correct temperature storage for refrigerated medicines. This means that people's medication was stored correctly within the recommended temperature ranges.

We saw that medication requiring special storage was safe and secure according to legal requirements. However, we found an envelope containing money stored inside this cupboard, which is not correct storage and increases the risk of unecessary access to people's medication. The manager informed us that this had only been placed in the cupboard that morning and it would be removed.

We were shown a medication policy , which was dated 9/6/08. It included details on disposal of medication, drug errors, procurement, storage, administration, controlled drugs and home remedies. This means that there was a procedure for staff to follow to ensure the safe handling and management of medication within the service. The manager informed us that all staff had access to this policy.

We saw current records for the receipt and disposal of medication.The date of opening of boxes and bottles of medicines were recorded. Balances of medication were not always carried forward from old to new records, particularly for medication prescribed on a 'when required' basis, which means that records did not always document what medication was available to administer to people living in the service.

We looked at the medication administration record (MAR) charts and found that they were usually documented with a signature for administration or a reason was recorded if medication was not given. We also found some people's MAR charts which had not been accurately recorded. For example, one person's MAR chart was not documented correctly and included a medication error which had not been notified to the manager. The prescribed medicine was to be given once at night, however we saw that it had been recorded on the MAR chart as given twice a day for two days, no record of administration on one day and given once in the morning on another day. It was therefore not possible from the records to determine whether the medication had been given or not on one of the days. We checked the medication available for the person and found that there were less capsules remaining in the box than there should have been, which meant that the medication had been given in error. We informed the manager that the records were not accurate and also that there had been a medication error. The manager informed us that she was not aware of the medication error and had not been informed. This means that a medication error had not been dealt with and the person's doctor had not been informed. We saw no record of the medication error

documented. The manager informed us that this error would be discussed with a member of staff. This means that the person's health and welfare was at increased risk due to the lack of accurate medication records, safe procedures were not followed and a medication error ocurred.

On the 10/09/09 two inspectors from the Care Quality Commission visited the home to complete the key inspection. However on entry to the home it became apparent that their were insufficient staff on duty for the peoples' dependancy needs. One carer was covering the three lounges, so people were left unsupervised whilst the carer was assisting people to the toilet. The nurse in charge had left the medication trolley in the dining room unattended whilst attending to an emergency upsairs, and three carers were covering the rest of the home assisting people with personal care. We were concerned to hear that, due to the staffing levels, the night staff had helped ten people with personal care before they went off duty. Given only two carers had been on night duty, they must have awoken people early to assist them with their personal care needs.

The findings from the observation assessment carried out by us evidenced that people were left in the lounges with the televisions on at loud volume. There was a slight delay between the televisions which created a noticeable echo which is distracting and disturbing. Residents observed hardly watched the television.

Staff interactions consisted of giving medication, which was late being administered, and offering drinks and trips to the toilet. Staff were seen walking through the lounges with no interaction with any residents. Staff appeared to only have time to assist people when assisting them to the toilet. We observed one person ask for the toilet at 10:55am. At 11:10am they were hoisted into a chair and 11:20 wheeled to the toilet - representing a 25 minute wait.

A comment received in a returned survey from a relative under 'what the home could do better' stated 'listen to patients when they are desperate for the toilet because sometimes they may have to wait a long time till there is a hoist free and two people to take them'.

We decided to stop the inspection and issue an immediate requirement notice for the home to provide additional staff to assist in meeting the health and welfare needs of people living at Havencroft.

It was confirmed on the 11/09/09 by the nurse in charge that additional staff had been rostered to cover the home and that things were much better.

We returned to the home on the 14/09/09 and tracked the care of three people who were using the service. We found some poor outcomes of care for

these people. The records reviewed showed that each person had an individual care plan. The care plan consisted of various A4 pages with information about the persons' health and very basic risk assessments. These were not completed in sufficient detail for staff to follow to assist them in meeting individuals' health and psychological needs.

We looked at the care documentation for a resident admitted for 'nursing care' with multiple complex nursing needs. The pre admission assessment provided little information about the person and what equipment and aids were needed to ensure their health was not compromised. The person completing the assessment had failed to sign the record. It was concerning to read on the initial assessment that the person had been discharged from hospital with no skin damage. Assessments completed at the home on the day of admission (09/07/09) confirmed that the person would be at high risk for developing skin pressure damage, however no record was available at that time for the equipment used to assist in reducing the potential. The general risk assessment dated 09/07/09 recorded 'needing air cushion and air mattress'. An entry in the daily records 01/08/09 stated 'terribly in pain due to pressure sore ----- for air mattress'. Recorded on the 02/08/09 '------ needs an air mattress' 04/08/09 'now has air mattress on bed'. The care plans were not dated and included multiple health problems in one document so it was difficult to monitor the progress of the individual. The nurses had also failed to include all the individual's known health care needs and potential risks into a care plan. For example, no care plan was in place for diabetes and the management of the condition, pain, and acute episodes experienced by the person.

A record on the 24/08/09 stated that the doctor prescribed antibiotics for an infected wound. On the 01/09/09 an entry stated 'to be referred to the tissue viability nurse'. From the records it is not clear whether this referral was made. Staff spoken with at the inspection were not sure if this had happened. The wound care charts are kept separate and failed to demonstrate the condition of the skin and progress of the wound.

There was little evidence in the care documentation that the individual or family had been asked about their preferences for care.

When the individual's condition deteriorated, the risk assessments had not been reviewed and updated, and neither had a care plan been implemented to assist the staff in providing quality end of life care. We looked at the daily care records and these showed gaps of up to four hours where no entry was recorded, and two hourly care at other times. We were told that no one stayed with the person whilst in the end stages of life, and they were alone when they died.

Documentation about the person to assist all staff in getting to know them and understanding their preferences had not been completed (which should include food preferences, life history, and social and leisure preferences).

For one person recently admitted to the home no risk assessment had been completed for nutrition. The person was in pain and a care plan had not been developed to monitor this and direct staff in delivering care.

A third person's care records stated that they had a 'sore bottom'.
There was different handwriting on the assessment, but only one signature and date. This is not within the Nursing and Midwifery Council's professional standards for record keeping, and could be detrimental to the person.

The home's general risk assessment for the individual stated 'malnutrition due to poor dietary intake, skin breakdown due to immobility and poor nutrition and incontinence'.
The care plan developed for the potential risk of pressure sores recorded 'pressure relieving mattress and cushions'. This had not been updated since 15/11/08. The person's assessment for skin damage scored '22', which equates to 'high risk' and this had not changed in the monthly evaluation. The manual handling assessment was dated 20/09/03 and monthly evaluations were recorded on a separate sheet. However if there has been no change with the individual the assessment should be reviewed and updated at least annually. This will ensure that staff have an accurate assessment in place for the person.

The nutritional assessment scored '12' which is high risk, however no referral to the dietician had been made. The care plan also told us that this person is 'unable to communicate their needs effectively'. This means that they are totally reliant on the nursing and care staff for everything.

At the time of the inspection this person was observed in the dining room sat in a wheelchair on a lifting sling. We observed two hot drinks placed in front of her during the observation. She did not drink at all and staff did not offer any assistance so the person had no fluids at all between 10.00 and 12.00am.
The person's fluid balance charts for the day recorded that they had received tea/coffee and this had been signed for twice for the morning period. The care plan records 'encourage to feed herself encourage and prompt as required, as ---- becomes bored and sleepy'. This had clearly not been followed by the staff.

The wound charts for people are kept separate to the person's care plans. These were examined and showed that the home had 11 dressings for the nurse to complete. The wound records failed to clearly demonstrate the progress of the wounds and what equipment and special instructions had been put in place.
Several entries in the accident records showed that people had received injuries from the hoists and wheelchairs. This would indicate that staff are either rushing people, or not using the equipment properly.

We looked at the daily care records for some people which are kept in the dining room, these showed that no entries had been made for many of the people. Whilst other records told us the frequency of baths and showers for example;

'-- showered 16/08/09, showered 30/08/09 no hair wash and showered 06/09/09 no hair wash.

'-- 20/08/09 bed bath and 03/09/09 bed bath'.

The bowel chart for -- 01/09/09 was the last entry and stated 'very hard stool'. This had not been followed up and the person may have been constipated.

We noted the water temperatures for one person stated '30 degrees' for all baths. We were told that they requested a cool bath, however this information was not included in the person's care file.

Comments received from the surveys from people using the service included: (under) 'Do you receive the care and support' two people said 'always', three people said 'usually' and one person said 'sometimes', (under) 'Are staff available when you need them?', one person said 'sometimes', three people said 'usually' and two said 'always'. Other comments received included; 'the home does everything well', 'friendly staff' and (need) 'more staff and more activities'.

The Annual Quality Assurance Assessment received from the home provided us with no information as to how the home had progressed in this area since the last key inspection. The last key inspection made a requirement for the home to improve the quality of the care plans, and recommended that they review more up to date documentation for assessments of people. Information was seized at the inspection using a regulatory notice and the Care Quality Commission may consider taking enforcement action against the home.

Daily Life and Social Activities

The intended outcomes for Standards 12 - 15 are:

12. Service users find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.
13. Service users maintain contact with family/ friends/ representatives and the local community as they wish.
14. Service users are helped to exercise choice and control over their lives.
15. Service users receive a wholesome appealing balanced diet in pleasing surroundings at times convenient to them.

The Commission considers all of the above key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

Standards 12,13,14 and 15

People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The social and nutritional care is not person centred to ensure people receive the stimulation and nutrition they require in order to meet their care needs and protect them from harm.

EVIDENCE:

The last key inspection recommended that the home review more suitable activities/therapies for people with more complex needs. Comments received from people using the service and staff felt that the home could provide more stimulating activities for the people living there. The Annual Quality Assurance Assessment received from the home told us, under, 'What the home could do better', 'increasing time spent on activities'. The home had not commented on improvements in the last 12 months.

The surveys received from people using the service told us if they felt there was sufficient activities. One person said 'always', two people said 'sometimes' and three people said 'never'. We were informed by the manager that the home is currently in the process of recruiting a person to be responsible for activities for 10 hours per week. Given the findings of our observational assessment this should be reviewed with consideration to increasing the available hours. People appeared bored during the inspection. We were told that current activities included 'mobility plus' once a week, an external entertainer once a week, and the carers play 'dominoes' etc with people.

The televisions in the lounges had been replaced since the last inspection, however there was a delay between the programs causing an echo which made it difficult to hear the sound clearly.

Care plans fail to specify whether the residents are offered a choice between male and female carers, given they have several male staff working at the home. The plans fail to recognise if the person's religious needs are being met. An entry on a care plan stated 'cover spiritual needs'. We are unsure what this means.

We asked staff if peoples' wishes were respected about what time they get up and go to bed. Staff were not sure that everyone's choice was met.

We spoke to the cook who has been in post for three years, and works six part time days, a carer with food hygeine certificate covers the seventh day. A tea lady works three hours every day.

The Environmental Health Officers' report issued requirements for the home to address around cleanliness of the kitchen. The cook confirmed that all requirements had been completed and they had been awarded a three star rating. We were informed that new cleaning schedules had been put in place and that the cook stays behind in their own time to ensure that the cleaning schedules are completed.

We were told that meal times and options are flexible and varied. People can have a full cooked breakfast seven days a week if they chose to or cereals, toast etc.

In preparation for the meal staff remove the table cloths and use paper placemats. The dining room is cluttered with a large number of wheelchairs being stored at one end. The patio doors are fixed closed from when the building work commenced on the extension. However this is now overgrown with weeds so does not provide a pleasant outlook for people. We received a concern that people were unable to go out when the weather permits. Staff confirmed that there was another entrance to the garden for people to use. The cook told us that the catering budget was sufficient and that the residents prefer traditional cooked food with at least three roast dinners weekly.

People were seen with drinks using plastic cups and plastic beakers, no risk assessments were in place supporting the reason why people were using plastic beakers. People were not being assisted with drinks and food where required - this being witnessed as part of the observational assessment.

Complaints and Protection

The intended outcomes for Standards 16 - 18 are:

16. Service users and their relatives and friends are confident that their complaints will be listened to, taken seriously and acted upon.
17. Service users' legal rights are protected.
18. Service users are protected from abuse.

The Commission considers Standards 16 and 18 the key standards to be.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

Standards 16 and 18

People using the service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

If people have concerns with their care, they or people close to them know how to complain. Outcomes of complaints are not being recorded so people cannot be confident they are fully addressed by the home. Staff need training about safeguarding people and procedures to follow when incidences of abuse occur in the home to ensure people are being protected from harm and neglect.

EVIDENCE:

We looked at the complaint records at the home, these showed that the home had recorded one complaint in the last 12 months. The response to the complaint did not offer a full explanation or record the overall result of their investigation.

We received three complaints since the last inspection, two of these were referred to the safeguarding multi agency team for investigation. Both were not substantiated. One was to do with the building work being incomplete, this was evidenced during the inspection.

We looked at the accident records and found several entries where residents have received injuries either from the hoist or the wheelchair. These accidents had not been further investigated, or passed to the appropriate authority to monitor under Regulation 37. Staff were unaware if accident audits were being completed to assist in monitoring the number and type of injuries sustained to people and build up a clear picture. Accident audits assists management in ensuring that staffing levels are effectively deployed in the home.

We spoke to nurses and carers during the inspection, not all staff had any understanding about safeguarding and were unaware of the whistle blowing policy.

Environment

The intended outcomes for Standards 19 – 26 are:

19. Service users live in a safe, well-maintained environment.
20. Service users have access to safe and comfortable indoor and outdoor communal facilities.
21. Service users have sufficient and suitable lavatories and washing facilities.
22. Service users have the specialist equipment they require to maximise their independence.
23. Service users' own rooms suit their needs.
24. Service users live in safe, comfortable bedrooms with their own possessions around them.
25. Service users live in safe, comfortable surroundings.
26. The home is clean, pleasant and hygienic.

The Commission considers Standards 19 and 26 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

19,20.22.23.24 and 26

People using the service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Parts of the home are in need of refurbishment to make it a more pleasant and a safer environment for the staff and people who use the service.

EVIDENCE:

Havencroft nursing home provides a mixture of 24 single and double bedrooms some offering en-suite facilities. The home is built on three floors all of which accommodate residents. A passenger lift is available to assist people with mobility problems to access all areas of the home. The ground floor is where

the communal lounges and dining room are located; the standard of decoration is exceptionally poor and carpets stained in these areas. The patio doors leading off the dining room have been locked due to the building extension work which is incomplete. We received a concern from a relative that having the patio doors locked was restricting for the people in the home. They had chosen the home because of its location and large grounds, but this year they have been unable to use them. The view from the dining room is poor because the building work is overgrown with weeds. The deputy manager told us that there is another exit from the rear of the home into the garden for people to use. This was not easily recognised and highlights that the signage generally around the home is poor and not helpful for people especially those with short term memory loss. The dining room is cluttered with wheelchairs which makes a large area of the dining room unusable, it is recommended that the home review storage space.

We looked around the home and saw that some of the bedrooms are personalised for the person using the room, and this gives a more homely appearance.

The maintenance person was in the process of decorating some bedrooms to enhance their appearance. Some areas of the home were odourous and floors in toilets badly stained. We spoke to the domestic who informed us that only one person is allocated 38 hours Monday to Friday and no week end cover. Given the high level of incontinence, the size and layout of the home, it is recommended that this is reviewed to ensure that people living in the home have an acceptable standard of cleanliness. The treatment room on the ground floor was odourous, and the lack of ventilation in this area only made the odour worse. It is recommended that the source of odour is investigated and if from clinical waste storage a review of this should also be undertaken.

At the time of the visit the hand cleaner bottles were empty in some toilets, a system for ensuring these are refilled should be in place to assist in reducing the risk of cross infection in the home.

All windows are restricted with a chain and the maintenance person checks these and the temperature of the hot water.

Given the high dependency of some of the people living in the home it is recommended that the beds are reviewed to ensure that they are suitable for using with specialist equipment. This assists staff in ensuring that people are assisted safely with the correct equipment.

We looked in the linen cupboard this was well stocked and the nurse advised us that they did not run short of linen, however the towels were discoloured, badly frayed and felt rough to touch, it is recommended that these are replaced and reviewed regularly.

We observed that room 19 had no window covering, the reason for this was not known.

The Annual Quality Assurance Assessment received from the service, recorded in the section 'what we could do better' in respect of the environment had been left blank.
Improvements in the last 12 months included:
'Refurbished the kitchen'.
'Refurbished several rooms including carpets and furniture, started the extension'
'New televisions's in all lounges'

The homes plans for improvement in the next 12 months are 'continue general maintenance, new lighting in the coridors, complete lounge extension and refurbishment'.

Staffing

The intended outcomes for Standards 27 – 30 are:

27. Service users' needs are met by the numbers and skill mix of staff.
28. Service users are in safe hands at all times.
29. Service users are supported and protected by the home's recruitment policy and practices.
30. Staff are trained and competent to do their jobs.

The Commission consider all the above are key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

Standards 27,28,29 and 30

People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

By not having sufficient staff to meet the health and social care needs of the people who use the service places them at risk of harm through neglect. Recruitment practices need to be more thorough to ensure people can be confident staff are suitable to care for them.

EVIDENCE:

Through the inspection we found poor outcomes of care for the people who use the service (refer to health and personal care and daily life and social activities sections). Surveys from people who use the service told us they need 'more staff always short, uses lot of bank people'. Surveys from staff told us, 'the care staff try their best with the amount of staff they have but more staff would be able to cope more with the residents changing needs'. 'Need to employ the right number of staff (carers) in line with the needs and the number of residents and their state of dependence (and not by other criteria)'

On the 10/09/09 we issued an immediate requirement notice for the home to provide additional staff sufficent to ensure that the health and welfare needs of the people living at Havencroft were not being compromised. On the 11/09/09 it was confirmed that the staffing levels had been increased and this was assisting staff to meet the care needs of people, given the size and layout of the home and the dependancy needs of the people being cared for. We were told that all the people had some degree of incontinence, three people were poorly and being nursed in bed, and the nurses have dressings and medication to do. There was little or no supervision in the lounges at the inspection, the medication was administered late, and the last person was not washed until 11:30am and that was with the night staff having assisted 10 people with their personal care needs. There were also professional visitors turning up and the telephone calls. This gives them little time for paperwork and maintaining accurate records. Staffing levels and skill mix should be calculated on the health and welfare needs of the people being cared for. This can change from shift to shift and should be reviewed at each shift.
A proportion of staff go off sick regularly with no notice to the home, and the home should ensure that the sickness policy is adhered to. When staff go off this impacts on the quality of care and more pressure for the staff having to look after the people. In reviewing staffing levels it may be of benefit to appoint an administrator for some hours, additional cleaning and housekeeping staff. Staff told us that they had been down to three staff on a late shift and generally morale was very low amongst the staff, who are working extremely hard to try and meet the needs of residents.
It is recommended that the off duty is redeveloped to identify the nurses, carers and ancillary staff on duty on each shift for the 24 hour period.

The Annual Quality Assurance Assessment received from the home told us under the heading 'what they do well' the home responded 'training and recruitment, flexibility of staff'
In the section 'What we could do better' the home responded 'better ability to recruit and use nurse and carer bank'
The homes plans for improvement for the next 12 months stated 'continue as we are'

Comments from the staff included:
'I feel that the home cares well for residents not just for the every day basic care such as washing and dressing and feeding. Staff will take the time to listen to the residents who may be a bit worried or upset about something'

' ore activities to keep them stimulated'

'teamworking, training - all staff are kept upto date on a range of courses, and the standard of care provided to the residents'

'Provide transport for residents outings'

'more money into the home for lounge decorating, new floor coverings and lighting. The extension stopped and the outlook is poor for people'

We looked at the staff training records for the nurses and carers it was reassuring to find that in excess of 50% of carers have completed NVQ level two or above qualification in care.
The records showed that staff had attended various training courses and refresher updates. These included:
Deprivation of Liberty, skin and wound care, dementia, diet and nutrition and moving and handling.
It was disappointing to see that the nurses have received little or no clinical training which is a requirement of their Nursing and Midwifery Council (NMC) registration.
We spoke to carers who confirmed that they had received induction training whilst waiting to commence work, the induction covered moving and handling and personal care for the residents. They worked with a senior carer for supervision when they commenced and had received formal supervision with the manager. When asked about safeguarding procedures one carer was unclear about the process and had not been made aware of the whistle blowing policy.
When specific questions about residents care was asked we received conflicting information to the information recorded in the care records. For example we were told that the individual was admitted to the home with a pressure sore, however the records stated that it developed in the home.

The nurses told us that they have been extremely busy and have been unable to complete the care records due to the workload. We were told that they do not receive a full handover because of the shift patterns and have to remain in their own time for additional information. Very low morale between the staff because of the low staffing numbers and this has been like this for many months. They find it difficult to finish medications at the correct times, wound dressings and complete the paperwork before finishing their shift. The nurses advised us that although the carers are very good, there are just not enough of them.

We examined three people's employment files (or staff files) - which all contained evidence that safe employment procedures had not been followed. Application forms completed by staff employed to work in the home contained incomplete information. For example, the details of one person's employment between the dates 11/01/07 and 05/02/09 were absent, while the written references retained on the person's file were not from the referees named on the individual's application form and, while their application form stated that the person would 'continue' to work as a kitchen assistant, details of this were not recorded on the application form. Some information presented leads us to question the accuracy and the authenticity of the employment records. For example, one referee had stated that they had known the applicant for 11 years although the person had only been resident in the UK for four years,

while the handwriting on one reference appeared to be very similar to the handwriting on the application form.
Another staff file stated that the person's date of commencement of employment within the home was 30/06/09 while one written (employer's) reference was dated 02/07/09 - after their commencement of employment within the home - and had been completed by a family friend rather than the person's most recent employer. The second reference was addressed to 'whom it may concern' - which would imply that the home had not requested the reference from the referee. The third staff file also failed to provide the staff member's most recent employer as a referee, whilst one reference was dated after the person commenced employment at the home. There was no evidence of training or assessment of clinical competencies held on the staff member's file.

Management and Administration

The intended outcomes for Standards 31 – 38 are:

31. Service users live in a home which is run and managed by a person who is fit to be in charge, of good character and able to discharge his or her responsibilities fully.
32. Service users benefit from the ethos, leadership and management approach of the home.
33. The home is run in the best interests of service users.
34. Service users are safeguarded by the accounting and financial procedures of the home.
35. Service users' financial interests are safeguarded.
36. Staff are appropriately supervised.
37. Service users' rights and best interests are safeguarded by the home's record keeping, policies and procedures.
38. The health, safety and welfare of service users and staff are promoted and protected.

The Commission considers Standards 31, 33, 35 and 38 the key standards to be inspected.

This is what people staying in this care home experience:

JUDGEMENT – we looked at outcomes for the following standard(s):

31, 33, 35, and 38. People using the service experience **poor** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The management of the home needs improvement to ensure it is run safely and in the best interests of the people who use the service.

EVIDENCE:

The Annual Quality Assurance Assessment (AQAA) told us nothing about management and administrative arrangements within the home as the section had been left blank. Furthermore, the AQAA - which had been completed by the home's manager - contained very little information with many sections left blank. It failed to demonstrate the home's progress and ability in meeting National Minimum Standards, there was a lack of understanding of the

seriousness of the issues identified during our inspection suggesting that the problems identified were as a result of somebody being absent through illness.

We received mixed messages about the home's management. Some staff felt management were approachable, while other people stated that management failed to act when concerns have been raised. People using the service told us they felt management to be 'approachable', and staff surveys told us that they felt supported by the manager.

We looked at the home's internal quality monitoring audits in relation to medication and care planning as the quality and management of these areas is poor. We viewed a completed medication audit that had been carried out by the home and noted also that a food hygiene audit had been completed on 11/06/09. Management were in the process of updating some of their policies and procedures, which help staff to know what action should be taken for a variety of situations, and staff supervision records were in place for the people whose employment records we had examined.

We were informed that the Responsible Individual for the home visits each week, but only focuses on financial issues and does not demonstrate any interest in concerns that people may have about the service. Internal staff communication was described as being an area of concern for staff particularly as staff meetings are infrequent. This does not help to keep the staff team cohesive, neither does it create a platform whereby staff are kept informed about issues and development.

Records made available to us indicated that the home does not actively get involved in people's finances, and appropriate records are retained.

SCORING OF OUTCOMES

This page summarises the assessment of the extent to which the National Minimum Standards for Care Homes for Older People have been met and uses the following scale. The scale ranges from:

4 Standard Exceeded (Commendable) **3** Standard Met (No Shortfalls)
2 Standard Almost Met (Minor Shortfalls) **1** Standard Not Met (Major Shortfalls)

"X" in the standard met box denotes standard not assessed on this occasion
"N/A" in the standard met box denotes standard not applicable

CHOICE OF HOME	
Standard No	***Score***
1	3
2	3
3	1
4	1
5	X
6	N/A

HEALTH AND PERSONAL CARE	
Standard No	***Score***
7	1
8	1
9	1
10	3
11	1

DAILY LIFE AND SOCIAL ACTIVITIES	
Standard No	**Score**
12	1
13	3
14	1
15	2

COMPLAINTS AND PROTECTION	
Standard No	**Score**
16	3
17	X
18	2

ENVIRONMENT	
Standard No	***Score***
19	2
20	3
21	X
22	3
23	3
24	3
25	X
26	1

STAFFING	
Standard No	**Score**
27	1
28	3
29	1
30	1

MANAGEMENT AND ADMINISTRATION	
Standard No	**Score**
31	1
32	X
33	1
34	X
35	3
36	X
37	X
38	2

Are there any outstanding requirements from the last inspection? Yes

STATUTORY REQUIREMENTS

This section sets out the actions, which must be taken so that the registered person/s meets the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The Registered Provider(s) must comply with the given timescales.

No.	Standard	Regulation	Requirement	Timescale for action
1.	OP3	14 (1) (a)	To ensure that peoples health and welfare needs are fully met the home should only admit people whose needs are assessed and the home can fully meet their needs.	31/10/09
2.	OP27	18 (1) (a)	The home must ensure that there are sufficient numbers of qualified, competent and experienced persons working in the home as are appropriate to meet the health and welfare needs of the people living in the home. **Immediate requirement notice issued**	10/09/09
3.	OP7	15 (1) (2) (b)	All people living in the home should have a care plan which accurately reflects their health and welfare needs and provides clear guidance for the staff to follow. This should be reviewed and updated to reflect any changes or at least monthly. **Remains outstanding from the last inspection report.** **To be referred to enforcement team**	31/10/09
4.	OP8	12 (1) (a)	The home should ensure that appropriate risk assessments	31/10/09

			have been completed, and any potential risks are dealt with to ensure that the persons health and welfare is not being compromised. This includes referring to other professionals for advice and treatment for people where it is required.	
5.	OP9	13 (2)	The service must make arrangements to ensure that all medication is administered as directed by the prescriber to the person it was prescribed, labelled and supplied for. This is to ensure that people who live in the service are protected from harm	31/10/09
6	OP9	13 (2)	The service must make arrangements to ensure that medication administration records are accurately maintained; that the reasons for non-administration of medication are recorded by the timely entry on the medication administration record; that the meaning of any codes are clearly explained on each record; and that the person administering the medication completes the medication administartion record in respect of each person at the time of administration. This is to ensure that people who live in the service are protected from harm.	31/10/09
7	OP9	13 (2)	The service must make arrangements to ensure that medication is stored securely to ensure the safety of people who live in the service.	31/10/09
8	OP9	13 (2)	The service must make arrangements to ensure that records are kept of all medicines received, administered and leaving the home or disposed of to ensure that accurate checks can be made on peoples medication.	31/10/09

9	OP26	23 (2) (d)	The home should ensure that all parts of the home used by people living their should be kept clean and in good decorative order.	31/10/09
10	OP29	19 (1) (a)	The home must ensure that all staff working at the home have been recruited following the correct procedure. including that the authenticity of the references are correct.	31/10/09
11	OP18	Reg 37	The home ensure that all accidents and injuries in the home are reported and passed on to the relevant authorities, to assist in safeguarding people living in the home.	31/10/09

RECOMMENDATIONS

These recommendations relate to National Minimum Standards and are seen as good practice for the Registered Provider/s to consider carrying out.

No.	Refer to Standard	Good Practice Recommendations
1.	OP12	To assist residents with more complex needs the home should review more suitable activities / therapies.
2.	OP30	It is recommended that nurses maintain their professional accountability by attending clinical training sessions
3.	OP11	The home should ensure that staff are clinically skilled and trained to ensure that people in the end stages of life receive quality care.
4.	OP24	The home should review all beds to ensure that they are appropriate for the needs of the person and equipment can be used safely with the bed.
5.	OP26	A system should be in place to ensure that towels are of an acceptable standard for people to use.
6.	OP19	The home should review the storage facilities for wheelchairs so has not to clutter the dining room.

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