Vmaria & Rawther UK Ltd

Havendene Residential Home

Inspection report

Front Street
Prudhoe
NE42 5HH

Tel: 01661835683

Date of inspection visit:
04 December 2018
06 December 2018

Date of publication:
28 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was the first inspection of the service since it was registered by new providers in March 2018. An unannounced visit took place on 4 December 2018 so the provider and staff did not know we were coming. A second visit took place on 6 December 2018 which was announced.

Havendene is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Havendene has accommodation for up to 25 people in one adapted building, including two shared rooms. The home is a former vicarage and the accommodation is over two floors. There were 18 people living here at the time of this inspection, including older people with learning disabilities, physical disabilities or living with dementia.

There was registered manager in place but they were not present during this inspection. An acting manager had been employed to cover the absence of the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the provider had breached two regulations of the Health and Social Care Act 2008. Practices in relation to bedrooms fire doors, laundry door, food safety and medicines storage were not always fully safe. The provider's quality assurance systems had not always been operated effectively to monitor the safety of the service and to ensure compliance with the regulations.

This is the first time the service has been rated as Requires Improvement overall. You can see what action we told the provider to take at the back of the full version of the report.

All the people and relatives we spoke with felt the home was a safe and comfortable place to live. Staff were clear about how to recognise and report any suspicions of abuse. The home was clean and odour-free.

The provider carried out checks to make sure only suitable staff were employed. Some staff had worked at Havendene for many years but had not had any recruitment refresher checks taken up since they were appointed. We have made a recommendation about this.

People told us they were happy with the care and felt there were enough staff to assist them. Staff had essential training in health and safety and care. However, they had not had supervision sessions for most of the year. The acting manager was addressing this.

People's consent and permission was sought before staff carried out any care. People were supported to

have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service did not always support this practice. For example, where people were subject to any restrictions to keep them safe, such as lap straps on wheelchairs, this had not always been recorded as being in their best interests. The acting manager was addressing this.

Before people moved to the home their needs were assessed to make sure the home could provide the right care. Staff worked well with other health care professionals and people were supported to access health services.

Relatives and health professionals said the staff responded quickly to any changes in people's well-being. People said the meals were very good. Staff encouraged people to eat and drink enough and they had choices about where to dine.

The building was a converted vicarage. Although it was warm and comfortable it had narrow, dim corridors and few design features to help people living with dementia. We have made a recommendation about this.

People, relatives and visitors said the staff were caring and kind. There were good relationships between people and staff and a warm, friendly atmosphere in the home. Staff spoke to people in a positive and encouraging manner. People's individual choices were respected and their dignity was upheld. Staff spoke about people with compassion and were sensitive to people's needs at the end stages of their lives.

People received personalised care that was based on their preferences and needs. Staff were knowledgeable about people's individual care needs and how they wanted to be assisted. People had opportunities to join in lots of activities and go out with staff into the local community.

People had information about how to make a complaint they were confident that these would be acted upon. They were asked for their views and felt listened to. People and relatives felt the acting manager and staff were approachable.

There had been a number of challenges to the home since the new provider was registered in March 2018. There had been a period of lack of management and changes to established staff. Relatives and staff felt there had been recent improvements but hoped that staff changes reduced.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Fire doors, laundry door, food safety and medicine storage were not always managed safely.

People felt safe and staff knew how to report concerns.

People told us staff were available when they needed them.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff had not had supervision for much of the year. Staff received training but training records were not fully up to date.

Staff had a good understanding of people's rights but had not always recorded decisions that were made in their best interests.

People enjoyed the food and their nutritional needs were met.

Health care professionals said the staff supported people effectively.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were kind, caring and friendly.

People were encouraged to make choices and to remain as independent as possible.

People were treated with respect and their dignity was upheld.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their specific needs.

There was a good range of in-house and community activities for people to participate in to support their social care needs.

The service had a complaints procedure in place and people felt they were listened to.

Is the service well-led?

Requires Improvement

The service was not fully well led.

The provider did not yet have an effective monitoring system to ensure sustained quality of the service.

There was a registered manager in post. They were not present at the time of the inspection. An acting manager was managing the service in the manager's absence.

People, visitors and staff said they acting manager was open and approachable. They felt improvements were starting to be made to the service.

Havendene Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 4 December 2018 and was unannounced. The inspection was carried out by an adult social care inspector and an assistant inspector. A second, announced visit took place on 6 December 2018 by an adult social care inspector.

Before the inspection, we checked all the information which we had received about the service including notifications which the provider had sent us. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. Due to technical issues on our part, the provider was not asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

We contacted the local authority safeguarding, contracts and commissioning team. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used feedback to inform the planning of this inspection.

We spoke with eight people who lived at the home and three relatives and friends. We asked two visiting health care professionals for their views. We talked with the acting manager, two senior care staff, two care staff and two cooks. We also talked with both directors of the organisation.

We looked at six people's care records, including medications records. We checked the recruitment records of three staff as well as staff training and supervision records for the staff team. We also examined records relating to the management of the service such as audits and
minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

The provider had not always carried out routine health and safety checks to make sure people's accommodation was safe. For example, there were no recorded checks of hot water from March to September 2018. This meant the provider had not assessed whether the water from washbasins, baths and showers were at a safe temperature for use by the people who lived there. Checks of window restrictors had also not been completed between March to September 2018.

There was no lock on the laundry room door which meant people could walk into that room unsupervised. There were people living at the home who were known to mistakenly enter different rooms during the day and night, so they would be at particular risk if they entered the laundry room. There were risk assessments about a person who entered other people's rooms but there was no sensor equipment in place to alert staff if they left their room during the night.

One person who used a wheelchair was accommodated on the first floor, which was their choice because they liked to be quiet and private. But there was no evacuation equipment in place to assist them to the ground floor if the lift failed or if they had to be evacuated in an emergency. The lighting in bedroom corridors on both floors was dim which could present a tripping hazard for people with reduced vision.

At the start of the inspection some bedroom doors were being propped open with chairs. These bedrooms had just been cleaned and were being aired. But there was no-one present in the rooms so fire protection was compromised because the doors were open. There was also a risk of people tripping on the chair legs if they entered the rooms.

The floor to bathrooms and toilets were not sealed at the base of toilet bowls or wall edges. This meant the floor to those rooms could not be kept hygienically clean.

Records of temperatures of fridges, food served and kitchen cleaning were incomplete so the provider could not fully demonstrate the safe service of food. We saw that care staff went in and out of the kitchen several times during the meal service to carry plates of food to the dining room. This practice could compromise the control of infection in the kitchen area. The acting manager stated the home had a hot lock trolley for transporting food but it was currently broken.

The room where medicines were stored exceeded the safe ambient temperature of 25°C during this inspection. There were no records kept of the temperature of this room so it may be consistently above the maximum temperature. This could alter the composition of the medicine.

These matters were a breach of regulation 12 of the Health and Social Care Act 2008 Regulation (Regulated Activities) Regulations 2014.

People and relatives told us they felt the home was a safe place to live. One person commented, "I feel very safe and comfortable here." A visitor told us, "(Name) certainly feels safe here. They are very happy and

would tell me if there was anything they didn't like."

People were very comfortable in staff's presence and actively sought them out for chats and to spend time together. A health care professional told us, "I have no concerns and never about how the carers are treating my patients."

Shortly after the provider took over the home there were some incidents that were not reported to the local authority in line with local safeguarding adult procedures. Since then all reportable events had been referred to the local safeguarding team and all staff had recently completed group training with the local authority in safeguarding vulnerable adults.

Staff understood their responsibility to safeguard the people who lived at the home. There was information for staff displayed in the office about how to report any concerns. Staff said they felt "well-trained" and "confident" about raising concerns and felt these would be acted upon by the acting manager. The form for recording individual staff supervision sessions included prompts for staff to discuss any concerns they may have and whether they knew how to report these.

People told us staff were available when they needed them. Most people spent their day in one of the ground floor lounges and at most times staff were nearby to attend to them. Staff felt that staffing levels were sufficient to meet the current people's needs. A care staff member commented, "Staffing is not unsafe. We can always ask for more staff for specific assistance, like if we're helping someone to an appointment."

The acting manager had recently introduced a dependency tool to calculate the level of support each person required and this was used to calculate the staffing levels for daytime staffing. At this time, the tool showed there should be three staff on duty during the day and evening. We saw there were three staff on duty throughout the day and evening. However, staff also had to carry out laundry duties and prepare the teatime meals. After the teatime meal we saw that the three care staff sat together to record daily reports in a room away from people. This meant there was no immediate assistance or supervision of people, including people identified as at risk of falling. The acting manager stated they would make sure that at least one staff remained in the lounges to support people.

There had been some turnover of staff since the new provider took over the home and new staff had been employed. Recruitment processes were in place to make sure new staff were suitable to work in the care home. These included application, interviews and reference checks. The provider also checked with the Disclosure and Barring Service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people.

Some staff had worked at Havendene for many years but had not had any refresher checks taken up since they were appointed. The provider stated they did not currently have a policy about how frequently they would take up DBS checks for long-term staff. They stated they intended to carry out updated DBS checks on all long-term staff soon and we saw this was also in their action plan.

We recommend the provider incorporates their future intentions regarding updated staff checks into its recruitment, selection and retention policy and procedures.

We looked at the management of medicines. Each person's medicines administration records (MARs) were kept together with their photograph and details of any allergies as well as the contact details for their doctor and supplying pharmacy. Medicines were received from the pharmacy in colour-coded blister packs and some were provided in boxes. Blister packs were returned to the pharmacy every 28 days when new packs

were received.

There were individual protocols for people who were prescribed 'when required' medicines so staff had guidance about when to give them. These included for example, medicines for occasional pain or episodes of agitation. Staff who were responsible for administering medicines had training in this and periodic competency assessments.

Risks about people's individual health and safety were assessed, managed and reviewed. For example, there were risk assessments in place for people who needed support to manage their medicines, skin integrity, nutrition, falls and mobility. Fire safety risk assessments were in place.

Accidents and incidents were recorded and acted upon. The acting manager carried out a log of any accidents or falls of specific people who were at risk of falls. They used this information to learn lessons about how to support people in a way that helped to prevent falls. For example, by referrals to the falls clinic, GP review of medicines and sensor equipment to alert staff to people movement in their bedrooms.

People and relatives felt there had been recent improvements to the cleanliness of the home. One person commented, "It's a lot cleaner now." The provider had an infection control policy and there was personal protective equipment (such as aprons and gloves) readily accessible for staff around the building. One staff member was the designated infection control lead for the service who checked hygiene practices. The acting manager had carried out a thorough infection control audit recently. The audit had identified a small number of actions to further improve the prevention of infection, but this would benefit from setting timescales for when the actions should be completed.

Requires Improvement

Is the service effective?

Our findings

We checked whether staff received training and support to carry out their roles. The acting manager had begun to update the training matrix for all staff and had identified where staff required refresher training. The training matrix showed most staff had completed essential training in health and safety subjects such as fire safety, first aid, moving and assisting and infection control. The provider stated they had plans to introduce a computerised training management tool that would identify when each staff was due refresher training. At the time of this inspection it was not possible to determine if new staff had completed essential training as this was not yet recorded. For example, a new member of catering staff did not have prior knowledge of modified food textures for people with swallowing difficulties (dysphagia) or how to fortify foods to improve people's calorific intake. The acting manager stated that this training would be sourced for the staff member.

Staff had not always received support in the form of supervision sessions. A supervision is a one-to-one meeting between a member of staff and their line manager and can include a review of performance in the workplace. There had been no supervision sessions with staff between February and October 2018. The acting manager had now put a schedule in place which showed most staff had recently had one supervision session.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

There were mental capacity assessments for some people in relation to whether they could make decisions about their care. One person was assessed as not having capacity and another person as having fluctuating capacity. However, there were no recorded best interest decisions about their use of restrictive equipment such as lap straps on wheelchairs and bath hoists. The acting manager stated these would be put into place.

At the time of the inspection there was not a register of any DoLS applications that had been submitted to the supervisory authority. In care files we saw some people's DoLS applications had been submitted over a year ago but due to a backlog in the local authority these had not yet been processed. It was difficult to tell what the progress of applications was and the acting manager stated they were going to contact the authority for clarification.

We saw that staff respected people's rights to make their own daily choices and decisions wherever their

capabilities allowed. One staff member commented, "People have different mental capacity, but everyone is entitled to make their own decisions (if they can)."

All the people we spoke with were complimentary about the quality of meals. One person said, "The food is lovely, they're very good cooks. It's all fresh and home-made." Another person told us, "The food is very good and they know I have a diabetic diet."

There was a person-centred approach to ensuring people received a healthy intake of food. The service had identified that a person was leaving food of certain textures and made various attempts to remove certain foods and try different textures. The service recognised that the person would eat blended food so served them food to this texture and this had been successful. There was only main dish served for the lunchtime meal, but alternatives were made to individual request.

A morning and afternoon 'tea trolley' round was available. People were offered hot drinks and biscuits. Nutritious shakes were available which staff had designed in the form of 'mocktails'. A visiting health professional told us, "I think they care so well for people that they live a long time. They are nourished very well. They have nutrition drinks and little recipes for them. Their weight is stable, I have no concerns."

We observed the dining experience. The acting manager informed us that there were plans to create a larger communal dining space to enhance the dining experience for people using the service.

People who required assistance with eating sat in the lounge where staff assisted them with patience and encouragement. Staff spoke to people throughout their meal and made sure they had had enough food and fluids. People who chose to eat independently in the lounge were given their own table with table cloths. People using the dining room were able to choose their seat within the dining room so they could sit with people with whom they were familiar and chatted throughout their lunch. Dining tables were not dressed and condiments weren't readily available on them.

People's nutritional and hydration needs were being met. No-one was at risk of losing weight and nutrition screening assessments were completed monthly to check people's weight and well-being. At this time people's body mass index (BMI) was not recorded. This would be useful as some people's weight was continually increasing.

Pre-admission assessments had been carried out before people moved to the service to make sure their needs could be met there. The home provided accommodation for people with physical and learning disabilities and for people living with dementia. It would be difficult to get more than a couple of people who used wheelchairs in the small lounges. The corridors were narrow and dimly lit and there was no dementia-friendly orientation for people to find their way around. For instance, there were no picture signs for bathrooms and no contrasting coloured handrails.

We recommend that the provider considers recognised national guidance in dementia design when planning any future refurbishment.

Relatives felt staff worked well together and handed over any important information to each other. For example, one relative told us, "The let me know about any changes in [family member] or if the nurses have been so I know what's happening. They keep each other informed and if I've asked for something, like the hairdresser, they pass it on and it gets done."

Senior staff used a handover book to pass over important information between changing staff shifts. These

documents were reflective of people's health needs, prompting staff to request advice from appropriate healthcare professionals, and ensuring that staff were aware of any interventions implemented such as turn charts or mat sensors. Further information sharing could be done between staff members of the service. The activities coordinator had vast knowledge of people and their backgrounds from certain activities they had held. However, they had no input into care plans and no methods of sharing this valuable individual information with other staff members.

People and relatives confirmed that people were assisted with access to health care services. Care records showed there had been good collaboration with other care services when necessary. These included GPs, falls clinic, behaviour team, optician and social workers.

The acting manager and staff commented on the good working relationship they had with other care professionals. A visiting healthcare professional made positive comments about the communication from staff when there were any changes in people's health and well-being. They told us, "They (staff) are very responsive, they know exactly when to call me, I work well with them."

Good

Is the service caring?

Our findings

People and relatives told us the service was caring. People's comments included, "I like the staff, they're lovely", "I have a good laugh with them" and "the staff are very nice".

A relative told us, "I am very happy with what I see when I visit in terms of care and kindness. (Person) says they are very happy here and they get on well with staff. One staff in particular has been brilliant with (person)." Another relative commented, "The staff are very friendly and caring."

People described the good relationships they had with different staff members. We saw there was good interaction and communication between people and staff throughout the day. Some people had speech difficulties and other people found it difficult to express themselves but all the staff were very engaged and in tune with each person's communication style.

People were clearly familiar and comfortable with the members of staff on duty. Staff were able to sooth and diffuse situations where people became confused or agitated. One person told a member of staff they were going home the next day and asked a staff member if they would miss them. The staff member replied that they would and asked them to stay for the weekend. Staff used appropriate and reassuring touch when a person sought comfort, and another person who showed signs of aggression was soothed by a conversation and gentle physical touch to the arms.

A visiting health professional was very complimentary about the care and respect shown by staff towards the people who lived there. They told us, "It's a wonderful place, extremely caring staff. If I had a relative I would be happy for them to come to Havendene. They treat these older people like they're their own mother."

In discussions staff felt the service was caring and person-centred. One staff commented, "The residents always come first, no matter what. We've stayed here even during difficult times because we care about the people."

People were supported to be independent where possible and continue to take part in tasks they were able to complete themselves. A local GP told us that although they visited the service regularly, those people who could attend the surgery were encouraged and supported to do so by staff. One person went out independently to local shops and this was promoted by staff.

We observed staff engaging with people in a respectful way. Staff knocked on people's bedroom doors before entering and we saw throughout the day that this was standard practice for care staff. One visitor told us, "(Person) prefers to stay in their bedroom as they always enjoyed their own company and this is respected. They always invite (person) to join in activities but they respect their decisions."

We found that advocacy hadn't been advertised within the service nor had referrals been made for people who may potentially need an advocate. An advocate is a person who represents and works with people who

need support and encouragement to exercise their rights. There were at least two people who could potentially need an advocate as they had little to no input from their families. The acting manager told us they would look into advocacy services in the local area.

There was an information booklet for people which was written in plain English and pictures and was easy to understand. There were copies of the booklet in the office but it was not clear if this had been given to newer residents as it did not refer to the new providers. The acting manager stated this would be reviewed and would check with people if they had this information and whether it was in the best format for them.

People's personal information and sensitive data was stored securely to uphold confidentiality and protect their privacy. We saw that records containing people's private details were kept locked away.

Good

Is the service responsive?

Our findings

People and relatives felt the service provided an individualised service. Staff were very knowledgeable about each person and spoke about their abilities as well as their needs. Staff were familiar with people's preference's and provided a flexible service to meet their preferred routines. We saw throughout care records that people were offered choices about how and who supported them and their preferences were respected.

Each person's care records included assessments about their individual needs, the level of support they required and their involvement in managing daily living tasks. Each person had care plans which set out guidance for staff about how to support them with their assessed needs.

Care plans had been developed to cover a range of care needs including mental capacity, cognition, social activities, continence and mobility. Care plans also covered people's individual religion and culture, enquired about sexuality and promoted people's rights such as to vote. The care plans were reviewed monthly. Care plans indicated that where staff supported people with tasks, people should be encouraged and helped to do as much for themselves as possible.

The care records were personalised to each person and written from the perspective of the person in a sensitive way which promoted each person's capabilities as well as needs. For example, one person's care plan about bathing stated, "I am a very independent private person. I go to the toilet when I want and in the bath when I fancy. I might ask directions but I can manage on my own." The action for staff included, "Care staff to guide [person] to the toilet but treat them with dignity and respect at all times."

Staff said the care plans directed them to work in the same way so they supported people consistently. For example, one person had a behavioural care due to the impact of their dementia. The care plan had been written by the acting manager with input from the behaviour team and social worker. A staff commented, "We have clear care plans so we can work in a consistent way with [person]. It has really helped to support their agitation."

People thought highly of the activities coordinator who arranged a wide range of activities and events. One person told us, "He's a lovely man, I enjoy his activities." Another person told us, "He is brilliant at activities and really get us involved. I like to be busy and they let me help out, and we go out to coffee morning and the shops."

The service had regular activities tailored to individual people's need and preferences and people were allocated one-to-one time with the activities coordinator to either have a conversation, engage in a meaningful activity or go out into the local community. Activities included quizzes, singing, games and crafts. People said they also enjoyed regular visits from pat-the-dog as well as children from local schools. On the first day of this inspection local children were presenting a Christmas concert and everyone in the home joined in.

People were supported to be part of their local community and enjoyed going out to a weekly coffee morning nearby and to local social clubs and events. The home was in the heart of a thriving local shopping area and people described how they regularly went out shopping with the assistance of staff.

The activities coordinator had good links with the local community such as the schools, churches and community groups. Regular 'chat shops' were held in which people using the service could engage in conversation about meaningful topics such as religion and festivals, Remembrance Day, hobbies and interests, their community, entertainment and voting.

People and relatives told us they had "no complaints" about the service but felt very comfortable about telling the acting manager or staff if they were not happy with anything. One person said, "I would say if I didn't like something, but I can't think of any improvements and I have no complaints." A relative told us, "I have no complaints but would feel very able to discuss anything I wasn't sure of with [acting manager] or the girls (staff)."

There was information in the service user guide in the office about how to make a complaint, although it was unclear if everyone living at Havendene had a copy of this. There was also a complaints procedure displayed in a ground floor corridor although this was in very small print and would not be easily seen by people or their visitors. The acting manager stated they would make sure the information was more prominently displayed. There had been no formal complaints received in the past year. The acting manager agreed to record any informal comments as well.

People had advance support plans in place, which described their preferences for their end of life care, who they wanted to be contacted and funeral arrangements. Staff had training in end of life care and saw this as an important part of their role. No one required palliative care at the time of this inspection but we saw gratitude cards from relatives about the care shown to former residents.

A visiting healthcare professional was also very complimentary of staffs' knowledge in recognising when people's health was deteriorating and ensuring that the relevant healthcare professionals were informed. They told us. "The staff know when people are declining, they know how it works when they're in the final decline of dementia. That's exactly the pre-emptive care you want for your relative. Now I can make arrangements for a meeting with their relative, do a review and put a DNACPR in place."

Requires Improvement

Is the service well-led?

Our findings

The provider's monitoring system was not yet fully in place to monitor the safety of the service. For several months after taking over the running of this service the provider had not carried out some safety checks or audits to assess the quality and safety of the service. These included checks of the temperature of hot water to make sure it was safe for use by people who lived there. For the past two months, since the acting manager had started working at the home, safety checks had started to be carried out.

There was no lock on the laundry door which meant people could walk in unsupervised. The provider had previously been advised by the local authority to fit locks to rooms containing equipment or confidential information. Locks had been fitted to offices and the kitchen but not to the laundry door so the safety of people who could access this room had not been considered.

Supervision sessions with staff to support their development and performance had not been carried out between March to October 2018.

There were a number of policies and procedures that were titled with the provider's company name but they did not always reflect the actual arrangements in the home. For example, the governance policy stated, "The overall lead for governance in the company is our CQC registered manager (name of an unknown person)." The person named had never been associated with Havendene so this was incorrect.

Several areas of the accommodation were worn and ready for redecoration, for example, torn wallpaper. Some people and visitors described the bedroom accommodation as "sparse" and "tired". The provider had fitted new flooring to one bedroom. However, the provider did not have a refurbishment plan in place or anticipated timescales for works to be carried out.

These matters were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The acting manager had commenced a series of audits since September 2018. These included checks of notifiable events, medicines and equality and diversity practices. A health and safety audit had commenced but had not been completed. Some audits had identified a small number of actions but timescales had not been set for when these should be completed.

There was a registered manager in place for Havendene but they were not present during this inspection. An acting manager had been employed for the past couple of months to support the daily management of the home during the registered manager's absence.

The people, relatives and health professionals we spoke with all commented positively on the open and approachable attitude of the acting manager and staff. One person told us "[Acting manager] is super – nothing is a problem to her." A relative commented, "[Acting manager] and the staff are all open and approachable. I can ask them about anything and they listen to me." A health care professional told us,

"[Acting manager] is lovely, very approachable and doing a great job."

Resident/relatives' meetings were held. These were an opportunity for people and relatives to make any suggestions or comments about the service. Also, a quality questionnaire had been used to gain people's views of the service they received and to incorporate their views into the way the home was run. For example, people had been asked in a multi-choice format about the quality of food and their preference so that menus could be changed and developed to meet their choices. Relatives felt the service was improving. One told us, "I feel Havendene has really moved on recently."

Staff said they felt more supported since the acting manager took up post. One staff commented, "Now we've got a key person to go to if we've got any concerns." Another staff said, "We weren't up to date before then we had a blip – but [acting manager] is really getting it back on track." Another staff "It's going in the right direction. [Acting manager] has made good changes."

People, relatives and staff had been affected by a number of staff changes in the past few months. Staff who had worked at the home for several years and were very familiar with people's needs had left the home. A health professional commented, "New owners come in make changes, and when staff have been here for a very long time its disruptive. I think it went through a period of unrest, new staff, managers, new owners." We talked with the provider about staff retention and continuity of care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks because the provider had not identified and acted upon risks to the health and safety of people receiving care. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality monitoring systems had not been effective to ensure the safety and quality of the service. Regulation 17(2)(a)(b)