Havencourt Care Home
Care Home Service

Woodcot Gardens
Forest Road
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Telephone: 01569 767 877

Type of inspection:
Unannounced

Completed on:
12 March 2025

Service provided by:
Havencourt Care Limited

Service provider number:
SP2020013463

Service no:
CS2020378891

About the service

Havencourt Care Home is a care home for older people situated in Stonehaven. It is registered to provide nursing care to a maximum of 42 older people. There is also provision for up to four people for respite/short breaks.

Stonehaven is a seaside town in northeast Scotland, with a range of local amenities that people can access. The service provides accommodation over two floors in single bedrooms with ensuite toilets and wash-hand basins. There are dining rooms and lounge areas on both floors, and there is an enclosed garden area.

About the inspection

This was a follow up inspection which took place on 12 March 2025. The inspection was carried out by one inspector from the Care Inspectorate.

To prepare for the inspection, we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service, we spoke with four people using the service (in passing). We also spoke with two members of staff (in passing) and three members of the management team. We observed some practice, daily life and reviewed documentation.

Key messages

* The service had made significant improvements in all aspects of falls management.

* Evidence-based tools had been introduced to support people at risk of developing pain and monitor the efficacy of pain relieving medication.

* The service had met with the local police to discuss the Herbert Protocol and partnership working.

* There had been a focus on anticipatory care and end of life care planning.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 6 March 2025, the provider must demonstrate that:

a) Relevant staff are fully informed about any changes in the general health, care, or support needs of people using the service.
b) Accurate, timely, and appropriate information is shared with the representatives of people using the service and other healthcare professionals involved in their care.
c) Ensure that advice from other healthcare professionals is sought in a timely manner when a resident's condition changes.
d) Make every effort to ensure that a clinician attends the care service when needed.
e) Ensure that written notes are detailed and accurate.
f) Ensure that handover documents contain appropriate and accurate information.
g) Ensure that all communication with residents' representatives is recorded within the residents' care file.

This requirement was made on 6 February 2025.

Action taken on previous requirement

We reviewed the minutes of a recent staff meeting (5 February 2025), which demonstrated that a serious incident had been discussed with the staff team. The incident had led to an upheld complaint. There was evidence of reflection, lessons learned and a focus on improvement.

The service was supported by the regional quality assurance lead, who worked closely with the management team in respect of clinical governance.

One to one supervision sessions had been carried out with staff to ensure they understood their role.

The deputy manager had led a recent project on falls prevention and management. A new and very thorough process had been rolled out, with the aim of reducing the risk of falls, ensuring residents are well cared for post-fall and accessing help from the emergency services or other healthcare professionals.

The new post-falls pack was accessible to nurses at all times. This importance of the full use of this pack had been explained to the nursing and senior staff. This included explanation of the RESTORE 2 assessment tool, pain assessment, neurological observations, 24 hour observations, accessing medical help, completing a body map, updating risk assessments and care plans, as well as communication with next of kin and allied health professionals.

This was a valuable piece of work, which demonstrated a commitment to improving outcomes for people. The Herbert Protocol had been included in the service's approach to falls management. The manager had recently met with Police Scotland, with a view to working in partnership to support resident safety.

This way of working was at an early stage; however, there was evidence to demonstrate that falls had recently reduced.

Supporting residents at risk of developing pain had been another clinical focus. It was positive to find that nursing staff were considerate of residents with wounds, checking their pain levels and offering pain relieving medication appropriately. It was positive to see body maps being used to demonstrate where residents experienced pain and the efficacy of medication.

Whilst the new approach to pain management was also at an early stage, there was evidence of positive outcomes for people.

Met - within timescales

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

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