The Haven Healthcare Limited

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Inspection report

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Date of inspection visit:
05 December 2018
07 December 2018

Date of publication:
03 April 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 05 and 07 December 2018 and was announced. The Haven Healthcare Ltd is a domiciliary care agency. It provides a nursing and personal care to people who, by reasons of old age, illness or disability are unable to provide it for themselves. It provides this service to people in their homes. At the time of the inspection the provider told us they were providing the regulated activity of personal care to only four people.

This service was inspected in January 2013 but did not have people using the service, and remained dormant until October 2018.

At this inspection in December 2018 we found breaches of fundamental standards and regulations. The provider had not acted to make sure medicines were managed safely. We found the provider had not taken action to support people where allegations of abuse were raised and to reduce the risk of similar future incidents. Recruitment practices placed people's safety at risk. The provider had not completed a risk assessment for every person when they started using the service. Staff did not always attend people's care calls as required by them.

Staff did not receive appropriate training and support to complete their roles safely. The provider did not ensure the safe assessment and care planning of all people's individual needs.

People and their relatives told us their privacy was not respected and staff had not acted in accordance with people's wishes. The provider had not followed their complaints procedure.

The provider did not ensure appropriate systems and processes were in place for the management of risk, safe recruitment of staff, safe management of medicines, staff training and overall governance of the service. The provider lacked oversight, understanding and management of the service and left the people at risk of harm. The provider had not ensured they monitored and analysed early or late visits so patterns could be identified and improvement made. The provider had failed to notify CQC of notifiable events.

There was no system to manage accidents and incidents to reduce the likelihood of them happening again. The provider had not completed health action plans for people who required. The provider did not have systems and procedures to ensure an effective joint-working with other services.

People and their relatives told us their privacy was not respected and staff had not acted in accordance with people's wishes. The provider had not given consideration for equality and diversity. Staff supported people to eat and drink enough to meet their needs. However, people did not have care plans about their diet and nutritional needs and this required improvement. The provider had involved people and their relatives, where appropriate, in the review of their care.

People gave us a mixed feedback about how their complaints were managed. The provider had a policy and

procedures in place to support people with end of life care in line with their wishes.

There were no staff meetings held to share learning, and good practice so staff understood what was expected of them at all levels. The provider had not maintained any records to show that they worked with health and social care professionals and commissioners. Staff described the management of the service positively. The provider had a policy and procedures to work with commissioners, health and care professionals. However, the feedback from commissioners was not positive.

People were protected from the risk of infection. The service had a registered manager in post. 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.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had not acted to make sure medicines were managed safely.

The provider had not taken action to support people where allegations of abuse were raised and to reduce the risk of similar future incidents.

Recruitment practices placed people's safety at risk.

The provider had not completed a risk assessment for every person when they started using the service.

Staff did not always attend people's care calls as required.

There was no system to manage accidents and incidents to reduce the likelihood of them happening again.

Staff followed infection control procedures.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not receive appropriate training and support to complete their roles safely.

The provider had not carried out an initial assessment of needs for each person to ensure they could be met.

The provider had not completed health action plans for people who required and monitored their healthcare appointments and this required improvement.

The service had systems to assess and record whether people had the capacity to consent to care.

The registered manager supported staff through supervision and spot checks.

Relatives supported people to eat and drink, and coordinated their health care appointments.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People and their relatives told us their privacy was not respected and staff had not acted in accordance with people's wishes.

The provider had not showed an understanding of equality and diversity.

The provider had involved people and their relatives, where appropriate, in the review of their care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider did not ensure the safe assessment and care planning of all people's individual needs.

The provider had not identified and met the communication needs of people.

People gave us a mixed feedback about how their complaints were managed.

The provider had systems and processes in place to support people with end of life care in line with their wishes.

Is the service well-led?

Inadequate

The service was not well-led.

We received a mixed response from people and their relatives about the management of the service.

The provider did not ensure appropriate systems and processes were in place for the management of risk, safe recruitment of staff, safe management of medicines, staff training and overall governance of the service.

The provider had failed to notify CQC of notifiable events.

There were no staff meetings held to share learning, and good practice so staff understood what was expected of them at all levels.

The provider had not maintained any records to show that they worked with health and social care professionals and commissioners.

Staff described the management of the service positively.

The Haven Healthcare Ltd

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 site visit took place on 05 and 07 December 2018 and was announced. The provider was given 48 hours' notice because the service is a domiciliary care service and we needed to be sure that the provider would be in. We visited the office location to see the registered manager and office staff; and to review care records and policies and procedures. The inspection was carried out by one inspector and one expert by experience. The expert by experience made phone calls to people to seek their feedback about the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. Due to technical problems, the provider was not able 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 also contacted health and social care professionals involved in people's support, and the local authority safeguarding team for their feedback about the service.

During the inspection, we spoke with two people and one relative, three members of staff, and the registered manager. We looked at three people's care records, and five staff records. We also looked at records relating to the management of the service, such as the complaints, accidents and incidents, safeguarding, health and safety, and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us they felt safe about how staff treated them. For example, one person told us, "Yes I do feel safe with the carers and if I didn't I would contact either Haven Health Care or Clinical Commissioning Group (CCG)." Another person said, "Oh yes most definitely I feel safe and I would contact the manager at Haven Health Care." However, we found concerns regarding medicines management, risk management and staff recruitment practices which meant that the service was not safe.

The provider had not acted to make sure medicines were managed safely. There were no medicines administration records (MARS) of the medicines people were prescribed. One member of staff told us, "I take medicines from the medicine box and dispense it to [name of person] in a small container, and give with a spoon and water. Then I observe [name of the person] taking medicine. I write in log book and sign, we do not have MAR chart." However, there was no list of medicines in the log book. People were at risk of not receiving their medicines as prescribed. We found the provider had not trained and assessed the competency of the staff authorised to administer medicines, meaning there was no way of knowing if staff were able to give medicines safely. Medicines care plans were not available to staff, so there was no information regarding what support people needed with their medicines. Staff were working without supervision, without clear guidance, leaving people further at risk. The provider had not carried out medicines audits to identify the systemic issues we found regarding medicines at this inspection. There was a risk that people may not receive the support they needed with their medicines and people may be supported with their medicines in an unsafe way.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy and procedure for safeguarding adults from abuse. The registered manager had told us staff had not completed safeguarding training and the training records we looked at confirmed this. When we asked the registered manager if there had been any safeguarding concerns within the service, we were told there had been none. However, Richmond clinical commissioning group informed us of two safeguarding investigations involving the service. The provider had not been honest about these concerns, and had not notified us as required by law. There was a risk that the provider may not have taken action to support people where allegations of abuse were raised and to reduce the risk of similar future incidents.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment practices placed people's safety at risk. The provider had not carried out satisfactory background checks of staff before they started working. These included checks on staff member's qualifications and relevant experience, their employment history and consideration of any gaps in employment, references. The provider had failed to complete any criminal records checks on staff or ask for any evidence of right to work in the UK or proof of identification. There was a risk of unsuitable staff working with people who used the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not completed a risk assessment for every person when they started using the service. The provider had failed to consider the risks related to areas including falls, fire, medicines management, and moving and handling. There was no guidance for staff on how to reduce risks. For example, where someone had been identified in their referral with a need for transfers using a standing hoist and required assistance of two staff, a risk management plan was not put in place which identified the use of equipment and the level of support the person needed to reduce the risk. The registered manager told us that they had not carried out risk assessments, and there were no management plans for staff to follow. There was a risk without risk management plan that staff may support people in an unsafe manner, or not in line with their preferences.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not deployed effectively. Staff did not always attend people's care calls as required. For example, people's comments included "No, this is the worst part of this agency. Often carers arrive at 6.30am when they should visit at 7.30am. this is far too early for me and my [loved one]. Then they [staff] are often late for the evening visit, they come at 8.45 – 9.00pm when it should be 7.30pm. this is too late for us as we go to bed early." "Not always, they[staff] often rush me and can just stay for 15 minutes for a half hour visit." Records were not completed to reflect the time staff departed from their care visits. For example, we looked at the daily record of care provision from 1 November 2018 to 11 November 2018 for a person and noted that staff recorded on all days that they visited at 7.00am, 12.00pm, 6.00pm and 8.00pm. The records did not show what time they departed. There was no information about how much time staff spent with this person. We also looked at the daily record of care provision from 9 November 2018 to 18 November 2018 for another person and noted that staff recorded on all days that they visited at 9.30am, 2.00pm, 4.00pm and 9.00pm. We found these records did not show what time they departed. There was no information about how much time staff spent time with this person.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no system to manage accidents and incidents to reduce the likelihood of them happening again, and this required improvement. The registered manager told us that there had been no incident or accidents that had happened since their previous inspection in June 2013. For example, what action staff would take to respond and minimise future risks, and who they would notify, such as a relative or healthcare professional, and how they would review each incident and who monitored them to identify possible learning.

People were protected from the risk of infection. Staff understood the importance of effective hand washing, using personal protective equipment (PPE) such as aprons and gloves and disposing waste appropriately, to protect people and themselves from infection and cross-contamination. The service had infection control procedures in place.

Requires Improvement

Is the service effective?

Our findings

People gave us a mixed feedback about how staff looked after them and if staff were knowledgeable about their roles. One person told us, "I try to communicate with the carers, but this is another big problem with this agency. We don't understand what three out of four carers are saying. Their English is extremely bad." One relative commented, "Yes, I am able to communicate clearly with the carers and we don't have any language problems."

Staff did not receive appropriate training and support to carry out their roles safely. The registered manager was unable to provide any substantive evidence that any staff member had received training and development to complete tasks safely. This included the safe use of mobility aids, catheter care, safe administration of medicine, safeguarding vulnerable adults, the Mental Capacity Act (2005), privacy and dignity, and equality and diversity. The registered manager told us that they would immediately identify all mandatory training for staff and provide them. However, they were unable to tell us by when all staff would complete all the mandatory training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not carried out an initial assessment of needs for each person to ensure they could support people appropriately with their medical conditions, physical and mental health; personal care, mobility, nutrition and skin care needs. The provider had not considered the level of support people required, their choices and preferences, and any identified areas in which they needed support. There was a risk without initial assessment of needs undertaken by the provider and without appropriate guidance that staff may support people in an unsafe manner, or not in line with their preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have systems and procedures to ensure an effective joint-working with other services and this required improvement. The provider had not maintained contact details of external healthcare professionals and GPs in every person's care record. There was a risk people may not receive well-coordinated care and support when they go to use other services. Relatives coordinated health care appointments and health care needs of people, as and when required.

Staff supported people to eat and drink enough to meet their needs. However, people did not have care plans about their diet and nutritional needs and this required improvement. One person told us, "They [staff] prepare meals, but I have to constantly make sure they understand what I want and how I want it prepared and cooked." Staff told us people made choices about what food they wanted to eat and that they prepared those foods so people's preferences were met. However, without care plans about people's diet and nutritional needs and without appropriate guidance that staff may support people in an unsafe manner.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. If the service wished to restrict the liberty of any person an application would have to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

The service had a policy and procedure to assess and record whether people had the capacity to consent to care. Staff understood the importance of asking for consent before they supported people. A member of staff confirmed they sought verbal consent from people whenever they offered them support. The provider had not recorded people's choices and preferences about their care and support needs. At the time of the inspection, the registered manager told us that people using the service had capacity to make decisions about their own care and treatment.

The registered manager supported staff through supervision and spot checks. Areas discussed during supervision included staff wellbeing, their roles and responsibilities, and their training and development plans.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us their privacy was not respected and that staff had not acted in accordance with people's wishes. One person told us, "The way they wash me, they are very rough with me. If I say I am freezing, because they have not covered me with a towel, they say 'I am nearly finished' and just carry on with no thought to my privacy or warmth." Another person said, "Two carers were kind and caring, but two other carers are very harsh towards me." Staff gave us example of how they promoted people's privacy and dignity which showed they understood the principles and had knowledge of how to ensure these. They told us, they properly covered people and closed curtains and doors when they provided care. Staff told us they kept people's information confidential. However, based on what people told us, we were concerned that staff may not be following these principles and values in practice

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not considered people's needs in relation to equality and diversity. For example, staff had not completed care records for every person who used the service, which included details about their ethnicity, preferred faith, culture and spiritual needs. However, staff we spoke with told us that the service was non-discriminatory and that they would always seek to support people with any needs they had with regards to their disability, religion, and gender.

People were supported to be as independent in their care as possible. Staff told us that they would encourage people to complete tasks for themselves as much as they were able to. A member of staff told us, "For oral care, I hold the brush for [them], and [they] would do everything for themselves under my supervision."

People and their relatives told us, where appropriate they were involved in the review of their care. For example, one person said, "Yes, I recently had a review of my care, and there was no change to the care needed." Another person said, "The manager came this week for a review, the first in a year." However, there were no care records available at the office to show that these reviews had taken place.

Requires Improvement

Is the service responsive?

Our findings

The provider did not ensure the safe assessment and care planning of all people's individual needs. They did not provide any documentation to evidence effective initial needs assessment; risk assessment of people's needs and care plans to ensure their safety. These included a lack of documentation for pressure area care, mobility needs, catheter care, feeding and administration medicines. They also did not include the level of support people needed and what they could manage to do by themselves. There was a risk without care plans being prepared by the provider and with appropriate guidance that staff may support people in an unsafe manner, or not in line with their preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not identified and met the communication needs of people and this required improvement. For example, there were no care plans which, contained information about people's communication needs and guidance for staff to gain consent prior to providing care in line with their preferences.

People told us they knew how to complain and would do so if necessary. People gave us mixed feedback about how their complaints were managed. One person told us, "Yes, I raised a concern when they sent me a male carer. I was happy with how it was handled." Another person said, "[senior staff] sends the carers. If they [staff] are late, [senior staff] just laughs and says someone will come. We don't like their approach, they are very unprofessional." The registered manager told us that they had not received any complaints since their previous inspection in February 2013. The service had a complaints procedure which clearly outlined the process and timescales for dealing with complaints and how to escalate if they remained unhappy with the outcome. People have told us they have made complaints, but the provider has not followed their procedure and documented this or responded appropriately.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy and procedures in place to support people with end of life care in line with their wishes. However, at the time of the inspection no one was receiving end of life care support from the provider.

Inadequate

Is the service well-led?

Our findings

We received a mixed response from people and their relatives about the management of the service. One person told us, "The service is very well managed." Another person said, "No, my [loved one] and I have more arguments because of the poor timings of the carers, its either too early or too late."

We found the provider did not ensure appropriate systems and processes were in place for the management of risk, safe recruitment of staff, safe management of medicines, staff training and overall governance of the service. The provider lacked oversight, understanding and management of the service and left the people at risk of harm. The provider had not ensured they monitored and analysed early or late visits so patterns could be identified and improvement made.

The provider was not open and transparent. When we asked the registered manager if there had been any safeguarding concerns within the service, we were told there had been none. Richmond Clinical Commissioning Group (CCG) informed us of two safeguarding investigations involving the service. Also, when asked the registered manager about the number of people being provided the regulated activity, the registered manager told us they were providing care to three people commissioned by Richmond CCG. However, Richmond CCG informed us that that the total number of people receiving the regulated activity were eight.

These issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify CQC of notifiable events. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. CQC then check that appropriate action has been taken. We found two instances of safeguarding that the provider and the registered manager had not notified us of, as required.

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

The provider did not have a clear vision and a strategy to deliver quality care and support to people and staff and this required improvement. There were no staff meetings held to share learning, and good practice so staff understood what was expected of them at all levels. The registered manager told us they used staff induction to explain their values to staff. However, there was no supporting evidence presented to show what was explained to staff during their induction.

The provider had not maintained any records to show that they worked with health and social care professionals and commissioners. Feedback from commissioners stated that the provider did not disclose the correct number of people receiving a regulated activity commissioned by Clinical Commissioning Group and about the two ongoing safeguarding concerns.

The provider had not carried satisfaction survey. One person told us, "Not yet no." one relative said, "No. it's

too soon."

Staff described the management of the service positively. They told us the service was managed well. However, we had no opportunity to observe the manager interacting with staff throughout the time of our inspection.

The provider had a policy and procedures to work with commissioners, health and care professionals. However, the feedback from commissioners was not positive.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Nursing care Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of notifiable events.

The enforcement action we took:
Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not carried out an initial assessment of needs for each person to ensure they could be met. People and their relatives told us their privacy was not respected and staff had not acted in accordance with people's wishes. The provider did not ensure the safe assessment and care planning of all people's individual needs.

The enforcement action we took:
Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not completed a risk assessment for every person when they started using the service. The provider had not acted to make sure medicines were managed safely.

The enforcement action we took:
Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken action to support

people where allegations of abuse were raised and to reduce the risk of similar future incidents.

The enforcement action we took:

Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not followed their complaints procedure.

The enforcement action we took:

Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found the provider did not ensure appropriate systems and processes were in place for the management of risk, safe recruitment of staff, safe management of medicines, staff training and overall governance of the service.

The enforcement action we took:

Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not carried out satisfactory background checks of staff before they started working.

The enforcement action we took:

Suspension of registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed effectively. Staff did not receive appropriate training and support to complete their roles safely.

The enforcement action we took:

Suspension of registration.