Haven House Care Limited

Haven House Residential Care Home

Inspection report

Limecroft Road
Knaphill
Woking
Surrey
GU21 2TH

Tel: 01483489197

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 12 April 2016. Haven House Residential Care Home provides residential care for people who have a long term mental health issue. The service is registered to accommodate up to 19 people. On the day of our inspection there were16 people at the service. The accommodation is a large house arranged over two floors.

There was no registered manager in place on the day of the inspection. 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 Regulations 2014 and associated Regulations about how the service is run. We were assisted by the provider and a new manager that had recently been recruited. They were waiting for their initial checks before submitting their application to become the registered manager.

On the 30 September 2015 we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service was rated as 'Inadequate'. We found on this inspection that sufficient improvements had not been made and the service therefore remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures .

At the last inspection of this service on the 30 September 2015 there were breaches around the staffing levels at the service, the lack of Mental Capacity Act assessments, people's nutritional needs were not always being met, safe care and treatment was not always provided, care plans were lacking in detail around the

specific needs of people and there was a lack of good governance at the service. We found on this inspection that there were still concerns and none of the breaches had been met.

There were not always enough staff deployed in the service to consistently meet people's needs. People were left on their own for long periods of time without the support of staff. Not all of the care staff on duty provided care to people, some were undertaking kitchen and laundry duties which left other staff to provide the care for 16 people.

Risk assessments for people were not always detailed. There was not enough information around of what staff needed to do to reduce the risks to people. Incidents and accidents were not always recorded in details or actions put in place to reduce the risk of incidents. There were aspects to the environment that were not safe for people, there were not always window restrictors in place and the bannister on one stair case was loose.

The premises and equipment was not well maintained. Areas that needed improvement had been reported to the provider had not been addressed for example in relation to people's bedroom furniture and fittings.

Medicines were not always being safely stored and there was a risk that people did not receive their medicines when they needed them. Medicines Administration Records (MARs) for people were signed for appropriately however medicines were not always disposed of safely by staff.

Although staff had knowledge of safeguarding adult's procedures they were not putting this into practice. Safeguarding incidents were not always being reported to the local authority. There was a safeguarding adult's policy in place. However the policy was not up to date with current legislation and did not have any contact details of the local safe guarding team. There was no safe guarding information on display in the home, this meant that people, visitors and staff would not know who to contact if they had concerns. The appropriate recruitment checks had not always been undertaken before staff started work. There were gaps in people's employment histories and references had not always been obtained before someone started work.

People's rights were not always met under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect them from harm. Assessments had not been completed specific to the decision that needed to be made around people's capacity. DoLS applications had not been submitted to the local authority around whether people's liberties were being restricted.

People were not always receiving care from staff who had received appropriate training. There was a risk that people were receiving care from staff who were had not had training around the needs of people with a mental health issues or behaviours that may challenge others.

Staff competencies were not always assessed with staff as they did not always have regular supervision with their manager. However the manager had started to undertaken supervisions with people.

People at risk of dehydration or malnutrition did not always have effective systems in place to support them. People whose diet was restricted were not provided with fresh and nutritious alternatives. Where people's food intake needed to be recorded this was not being done. However people had access to health care professionals to support them with their health needs.

Staff at the service did not always treat people with dignity and respect. There were times where people were ignored for periods of time throughout the day and people's dignity was not always maintained. People were not always consulted about the care they wanted. We did see times when staff were caring and considerate to people.

People's preferences were not consistently being sought by staff. The provider was not always responsive to people's needs. There was no detailed information in people's care plans around the support they needed. There was a lack of detail around care for people with a mental health diagnosis.

There were not enough activities on offer specific to the needs of people. There were long periods of time where people had no meaningful engagement with staff. Other people were able to go out independently.

Staff had not received annual appraisals to discuss their performance or training and development needs and some staff told us they didn't feel valued. However staff did say that they liked the new manager and felt supported by them.

There were not effective systems in place to assess and monitor the quality of the service. Although some audits had been undertaken these had not been used to improve the quality of care for people. Records were not always completed accurately and were not always complete. 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. The provider had not informed the CQC of significant events.

Personal evacuation plans were not in place for every person who lived at the service. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe.

There was a complaints procedure in place however not everyone knew how to access this. Complaints were not always appropriately responded to.

People had access to a range of health care professionals including GPs, community nurses, the community mental health team, dentist and opticians.

During the inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any 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.

There were not always enough staff deployed at the service to meet people's needs.

Risks of harm had not always been managed. The environment had not always been maintained to a safe standard.

There was a risk that people were not receiving their as prescribed. Medicines were not always stored and disposed of safely.

People told us they didn't always feel safe and staff did not understand their responsibilities in relation to abuse and reporting this to the safeguarding authority.

Safe and robust recruitment practices were not always followed.

Is the service effective?

Inadequate

The service was not effective.

People's human rights were at risk because the provider had not followed the requirements of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff did not always have the most up to date training to be able to meet people's needs. Staff's competencies were not always assessed.

People were not always provided with nutritious food and drink and people's nutrition risk was not always monitored.

People had access to healthcare services to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

There was institutionalised practice by staff in the service which meant that people did not always lead independent lives.

People's dignity was not always respected. We did see occasions where staff were kind and considerate to people.

People and relatives were not always consulted around preferences of care and people's rooms were not personalised to them.

People told us that at times staff were not always caring.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

There was not always the most up to date information available to staff about people's care needs. Changes in people's support needs were not always met.

There were not enough activities that suited everybody's individual needs. People said that there wasn't always a lot to do.

People did not always know how to access the complaints policy and appropriate systems were not in place to effectively handle complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured that there were appropriate systems in place to monitor the safety and quality of the service. Records were not always complete and accurate.

Where people's views were gained these were not used to improve the quality of the service.

Staff told us they did not always feel valued.

The provider had not ensured that notifications of significant events in the service had been made appropriately to CQC.

Haven House Residential Care 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 was an unannounced inspection which took place on the 12 April 2016. The inspection team consisted of three inspectors one of whom had a background in mental health care.

Prior to the inspection we reviewed all the information we had about the service. We had received concerns prior to the inspection that people were not receiving the care that they should, that people were not going out or undertaking activities and that food for people was restricted. Other information we reviewed included information sent to us by the provider about the staff and the people who used the service. As we undertook this inspection due to concerns we had we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications that had been sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we spoke with the provider, the manager, seven people that used the service, three members of staff and one health care professional. We looked at seven care plans, three recruitment files for staff, medicine administration records, supervision records for staff, and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. We observed care being provided throughout the day including during a meal time.

We last inspected Haven House on 30 September 2015 where the service's overall rating was inadequate

and it was placed in special measures.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to staffing . The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the registered provider had not made the required improvements to ensure there were enough staff to meet the needs of people.

People were left without support from staff when they needed it. On this inspection people told us that there were not enough staff. One person told us "They could do with more than one member of staff at night." Another person told us "They don't always have enough staff in; sometimes I just want someone to talk to." Whilst another person said "They are short staffed, you have to wait for such a long time if you want anything." This person told us that staff response to them when they needed them was "We will see to you when we can."

People's needs were not always met because there were not enough staff deployed at the service. There were times throughout the inspection where people were left on their own for long periods of time. One person chose to stay in their room however staff were not available to spend time with the person which left them socially isolated. There were unable to spend any meaningful time with people around other areas of the service. Some people chose to sit in the living room, however staff did not have time to sit and talk to people in a meaningful way. Most of the interactions between staff and people was restricted to meal times in the dining room. Another person was left asleep at the dining room table after lunch for a period of 30 minutes before staff saw that they were there. This was because staff were busy with duties elsewhere.

The staffing rota did not reflect how many staff were available to provide care. The provider told us that three care staff were needed during the day and one care staff at night including one sleeping member of staff at night. They told us that they had intended to recruit a cook for the service but said that they had changed their minds about this as staff levels had been increased since the last inspection in September 2015. However we found that of the three carers on duty one was in the kitchen preparing lunch for most of the morning whilst another carer was providing personal care to all of the other people at the service. The third carer rotered on was the provider. There was no extra provision to provide personal care to people and left 16 people being supported by one member of staff. One member of staff told us that when the provider was rostered on to work they didn't work as a carer.

We asked staff whether they were enough staff to meet people's needs. One told us "I can't remember the last time I was able to do any activities with people." They told us that although three care staff are rostered on to work the third carer "Never did any care work." They said that the third carer was usually the provider who was usually in the office or taking people out on appointments. The manager told us that the distribution of work needed to be addressed as at the moment one care staff spent a lot of their time in the kitchen cooking leaving the other carer to do all of the personal care.

Staff raised concerns about the distribution of care tasks. A staff member told us, "I have to go through a

worksheet and haven't got the time to complete everything. Some people do a little whilst others do a lot." They said "The workload is having a significant impact on people who live at the home, as staff cannot give good quality care in the time they have due to workload." The provider told us that they needed to look at the distribution of work by staff and that they would address this.

There were not always sufficient numbers of staff deployed around the service to ensure that people's care and treatment needs were being met. This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in September 2015 risks to individuals were not appropriately managed. Risks assessments lacked detail and window restrictors were not in place to prevent people from falling out. There were no personal evacuation plans for people in the event of an emergency.

People's safety could not be assured because not all identified risks of harm were appropriately managed. Risk assessments were not reviewed regularly or managed appropriately to keep people safe. Risk assessments were not detailed around malnutrition, choking or moving and handling. There were no clear guidelines on the action that should be followed by staff to prevent the risks. There were people at the service who smoked. There were no smoking risk assessments for any of these people despite there being guidance in the office from the local authority around the risks of people smoking. We found that accidents and incidents were not always recorded and there was no evidence to show what action had been taken to reduce the risk of falls and incidents for individuals. There were two incidents between people at the service; no action had taken place by staff to look at how these incidents could be prevented in the future.

We found that although a window restrictor had been put on one person's window there were six other rooms that people lived in where there were no window restrictors in place. The provider told us that they thought that window restrictors were there to prevent intruders coming into the service. They told us that they had not understood that the window restrictors should be in place to prevent the risk of people falling out of the windows. They told us that they didn't feel people were at risk. However one person told us "I have to ask a member of staff to open my window for me as they say it's not safe for me." We found that bannister on one of the stair cases in the service was loose and moved when you walked down which presented a risk to people who used them. Although there were now personal evacuation plans in place these were not regularly updated. One person had moved into the service recently and there was no personal evacuation plan for them.

People were not always protected from the risk of harm. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment and equipment had not been well maintained. One person showed us that the plug for their sink in their room had not fitted since being at the service. They told us that they had reported this to the provider for the past two years but that this had not been addressed. Another person showed us where the vanity unit in their room had come apart at the back. In another room, one door lock wasn't working and staff were using a screwdriver to gain access. Staff told us these issues had been reported to the provider a long time ago but we found no evidence of this in the records or why this had not been addressed. One vacant room was being used to dry laundry. There were a pile of duvets which a member of staff told us were the spares. However two of the duvets were heavily stained and discoloured and in one person's room a chair was heavily stained. The door to the downstairs bathroom did not close properly leaving a gap in the door when people were in there.

The environment and equipment had not been well maintained. This is a breach of regulation 15 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were put at risk of unsuitable staff working at the service because the appropriate checks had not always been undertaken on staff before they started work. There were documents missing in relation to references and criminal records checks were not always being reviewed. There was not a full employment history for two members of staff. According to the rota a new member of staff was due to start the night of the inspection. There were no references for this member of staff. The provider told us that they would undertake phone references that day however to date we have not been provided with any evidence that this was undertaken.

The failure to ensure recruitment checks were undertaken is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always recorded, stored and disposed of safely. There was a risk that people were not receiving the correct medicines. Two people's Medicine Administration Charts (MAR) had been handwritten but were not dated. They did not contain information around the amount of medicines received for these people. There were no guidelines for the medicines including their strength and frequency to ensure that the person received the correct medicines.

There was a risk that people were not receiving their medicines when they needed. Although there was a homely remedy (non-prescription medicine that is available over the counter) in place for the service these were not specific to the people who lived there. The PRN (as required) protocols were not detailed around when people may need them and how often before guidance was sought from health care professionals around whether regular prescriptions were needed. One person's medicine dosage had been increased in April 2016 but staff had not recorded who changed the prescription. Some of the dates of the medicines went back to December 2015 and January 2016. There was no evidence around why these medicines had not been completed. We asked a member of staff about this but they were unable to tell us whether people should have received this medicine or not. There was also no audit trail of what medicines had been returned to the pharmacy or when and the amount of medicines received into the service to give assurances to the staff that only the appropriate medicines were kept at the service.

We asked staff about the training they had received around medicines and how often their competencies were assessed. One told us "I did have some a long time ago; someone came to talk to us about it but not recently." We looked at the training records and saw that staff had not received refresher training and had not been assessed in the safe storage, handling and administration of medicines.

People were not always being administered medicines in a safe way. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were areas where medicine was being administered safely. There were no gaps in the Medication Administration Records (MAR) reviewed. All of the MAR charts had up to date photographs of people and there was detail around allergies that people had.

Systems and processes were not put in place to protect people from the risk of abuse. We saw that two incidents of alleged abuse between people had taken place which had not been referred to the local authority. Although staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse they were not putting this into practice. There was a Safeguarding Adults policy which was out of date and needed reviewing in 2012. The new manager had picked up on this and said that all of the policies were out of date and needed updated guidance. There was no information displayed

around the service to guide people and staff on what to do if they suspected abuse. The provider told us that they had assumed that all of the safeguarding referrals had been undertaken by their previous manager but told us that they had not been reviewing this.

People were not always protected from abuse. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our previous inspection we found breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) . The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the registered provider had not made the required improvements to ensure that people's capacity had been established.

The 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's human rights could be affected because the requirements of the MCA and DoLS were not always followed. People were at risk of having decisions made for them without their consent, as appropriate assessments of their mental capacity were not completed. There was no evidence that any mental capacity assessments had been completed. We found instances where decision making had been taken away from the person. Assessments of their capacity to make these decisions not been undertaken. One person was told by the provider that it was in their best interest of their health not to have their cigarettes but instead had to ask staff each time they wanted one. The provider told us that had been no capacity assessment for the person but the decision had been made because it was better for them. Another person told us that they had to ask permission to have their window open in their room. There was nothing in their care notes to suggest that they were unable to make that decision for themselves.

In one person's care plan it stated that capacity assessments should be undertaken as this person was living with dementia. The care plan stated that the person lacked capacity over their finances however there was no evidence of the assessment that took place to determine this. Another person had undergone a medical procedure at hospital and staff had signed the consent form. However there was no evidence to confirm whether the person understood the treatment or who made the decisions that the treatment was in the person's best interest.

The provider told us that they had undertaken assessments of people's capacity. However when we reviewed their care plans there had been none undertaken. The provider said that they misunderstood what was meant by MCA assessments and had mistaken this for people's mental health assessment. They told us that they had not had any training around MCA and did not understand the requirements. Staff did not have an understanding of how people had the capacity to make decisions about their care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Two of the people at the service told us that they didn't want to be there. There was no evidence

that applications had been submitted to the local authority in relation to whether their liberty was being restricted.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to appropriate training, support or supervisions for staff. The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the registered provider had still not made the required improvements.

We asked people whether they felt staff understood their mental health diagnosis. One person told us "Some staff understand my (condition) but not others." Another person said that the provider understood their mental health needs but wasn't sure about other staff.

People did not always receive care from staff that had the training and experience to meet their needs. There were times during the day where staff did not provide care in the most appropriate way. Two people at the service had been diagnosed with diabetes which was diet controlled. One member of staff was able to tell us what the person's blood sugars levels should be at and the signs to look out for should they become unwell. However when asked what alternative puddings the person would be offered they showed us a yoghurt with19% sugar. They said they could have fruit if they wanted but didn't acknowledge that the yoghurt may be harmful to them because of the sugar levels.

One member of staff told us that they didn't have an understanding of the needs of people with mental health issues. Another member of staff had worked without completing all of the service mandatory training. They also told us that they had no training or understanding of the needs of people with a mental health diagnosis and felt they could have had more training before they started work there. The provider sent us evidence that staff had received training around mental health but this did not apply to the newer members of staff who had started work there in the last two months and the training was not effective. There was no formal induction process; staff told us that when they started work they would observe other carers for one or two shifts. They told us that training was mostly e-learning and that they were not required to complete it before they started work.

People were not always cared for by staff that were competency assessed in relation to the work that they carried out. At the time of our inspection the new manager had undertaken one to one supervisions with two members of staff. However they had not had the opportunity to assess the competencies of staff. There was no evidence that other staff had received supervisions with their manager prior to the new manager starting. None of the staff had received annual appraisals to discuss their performance over the year or their further training and development needs.

Staff were not always suitably supported, competent and skilled in their role. This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to people not having access to fresh and nutritious food and people who had lost weight were not being monitored. The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the registered provider had not made the required improvements to ensure that people's capacity had been established.

On this inspection we asked people their views on the food. There were mixed responses including "The menus are different, better" and "The food used to be dire, but it's a bit better, they give us food out of a tin, cheap horrible basic food, the Irish stew is horrible" and "Some mornings I can have cornflakes, sometimes I can have porridge, the food is good" and "I'm not keen on the food."

People at risk of dehydration or malnutrition did not always have effective systems in place to support them. One person during the inspection was unwell and wished to remain in bed. The person told us that they were hungry. Their care plan stated in March 2016 '(The person) to eat a balanced diet and to monitor food and fluid intake. There was no system in place to monitor food intake and that a balanced diet was being eaten. Staff did not have knowledge of when the person last ate and whether what they had eaten was nutritious. One member of staff told us "I try to take them something to eat but I'm not sure this always happens." The person's choices around food were limited and we were told by staff that if they refused a meal they would make them a sandwich. There was no evidence of the last time this person had been weighed or what steps had been taken to support and encourage the person to eat.

There were people at the service who had diabetes however their choices around their meals were limited. We asked if there were healthier alternatives to full sugar jams and desserts and we were told there were not and that the person would be offered fruit. Another person was lactose intolerant; there were limited options on the menu for person. One member of staff offered this person a fizzy drink as an alternative to a hot drink. They told us that they did not have a good knowledge around what food this person could and couldn't have.

The food in the kitchen mainly consisted of basic value food which was either frozen or from a tin. There was fresh fruit in bowls but we didn't see staff offer these to people or people helping themselves to the fruit. One member of staff told us "The food is cheap, horrendous slop, the potatoes often have roots growing from them and they are still used for meals." There was no list in the kitchen of people's dietary needs including whether people required softer food, people who were diabetic or vegetarians. On the day of there was chicken on offer which had been made with a stir in sauce and the alternative on offer was tinned chilli con carne. There was no vegetarian option on the menu all week. One member of staff told us that the person who was vegetarian was only offered something from the freezer but often this looked "unappetising." Drinks were provided to people at certain times during the day but we didn't see people offered drinks outside of these times.

The service was not always meeting people's nutritional and hydration needs. This is a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did have access to a range of health care professionals, such as the GP, Community Mental Health team, dentist and opticians. On the day of the inspection one person was being taken to a health care appointment. We also saw one health care professional visiting the service on the day. One health care professional told us that they didn't have any concerns around the care of the person that they visited.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to care and treatment not being designed with the input of people who used the service. The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the registered provider had not made the required improvements to ensure that people's capacity had been established.

People were not involved in their care planning. One person told us "They don't sit me down and involve me in my care plan, I don't feel included at all, I just go along with the rules." The care plans we looked lacked personalisation and there was no evidence that people or their representatives were asked what they wanted. People did not have an opportunity to comment on their care planning or whether their needs were accurately reflected. The provider told us that they had asked people if they wanted to sign their care plans and be included. They told us that people just said they didn't want to. However there was no evidence around how people were asked to be involved or what steps the provider had taken to try different ways of involving people.

People were not always supported to be independent. One person told us "I would like to go food shopping, myself and cook my own dinner." We asked staff if they encouraged people to be more independent and involved in their recovery and staff said "No, we don't encourage people to cook for themselves. It might be dangerous." Another member of staff told us that they were told by a senior member of staff not to "Pamper" people. However those that were able did go out independently during the day.

There was institutionalised practice from staff in the service. People on the whole were accepting of the way they lived there lives at Haven House. However when asked if they felt that Haven House was their home. One person told us "I don't like living here but it is better with (the new manager), for the first time since she has been here I've been told I can have a shower every day instead of only twice a week." We were told by one person that they were not allowed to have drinks in the lounge and that all meals and drinks were handed out at the hatch by the dining room at certain times during the day. We saw that meal and drinks were provided to people in this way.

One member of staff told us that they had started to make someone a hot drink for one person and was told by a senior member of staff that they couldn't yet because it wasn't time to. They told us that they believed the service was run in an institutionalised way. One member of staff said "People's lives are not enriched here, there is nothing for them." The provider told us that they could see why it could be perceived in this way and agreed that care that people received was institutionalised and they knew changes needed to be made.

People's rooms were not personalised and lacked the homely feel. People told us that they were not involved in how their rooms were decorated and did not have an opportunity to choose their curtains or furniture. One member of staff said "The rooms are horrible." One health care professional told us that the

bedrooms were very sparce and not very homely. Rooms had a mixture of furniture that looked worn and in need of repair. However people did have their own personal belongings in their room.

The provider had not ensured that care and treatment was provided that met people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always treated with dignity and respect. On the day of the inspection one was person was being assisted with personal care in the downstairs bathroom. The door would not shut properly and we saw that this person was naked which was undignified. One member of staff told us that they had spoken to a senior member of staff being unhappy at the service. They told us that response they received was "It's their mental health, that's what they're like." They told us that when staff arrived at the service each day they didn't always say hello to people who lived there.

Staff did not always treat people in a dignified and respectful way. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were times during the inspection where people were treated with dignity and respect. We saw staff knocked on people's doors before entering and we asked if they wanted to wear clothing protectors. When staff talked with people in their rooms they closed the door behind them so that the conversation was in private.

We asked people whether staff were caring towards them. There were mixed responses including "(Staff member) can be rude, sometimes they can be grumpy." They told us that another staff member was "Always brilliant with me." Another person said "They (staff) just don't care what they do, it's not very good." Another person told us "The staff are friendly" whilst another told us "The people who work here are nice."

There were times where interactions between people and staff on the day showed staff to be caring and compassionate. For example, during the observed lunch one person would become distracted from their food. One member of staff stood near to this person, gently encouraging them to eat. We observed similar interactions throughout the day. We saw times where staff anticipated the needs of people and offering help and assistance. One health care professional told us that they had always observed staff to be caring towards people.

People told us they were offered day to day choices and freedom. One person said, "We have choice. We can have a bath or shower and can have them anytime we want." Another person said, "I can go for cigarettes whenever I want."

Inadequate

Is the service responsive?

Our findings

People did not always receive care and support that met their needs. The provider's statement of purpose stated 'we will monitor psychological health and ensure that preventative and restorative care is provided'. We saw no evidence of this taking place on the day of inspection. Care plans lacked any guidance for staff on how best to support people with their mental health or other needs. One person's mental health had deteriorated as a result of them not taking their prescribed medicines. Staff did not have a responsive plan in place to deal with this decline or the person refusal to take medicines.

Care plans were not always up date and therefore did not accurately reflect people's needs. One person's care plan stated that they were at risk of 'self-neglect' and that this would include their personal hygiene and eating and drinking. The person had been admitted to hospital previously due to their mental health. The advice from a health care professional was that the person required monitoring around their mental health and wellbeing, their dietary intake, their medicines and the risk of neglect. However the guidance for staff was that the person did not require 'intervention' from staff around their continence, skin care, mobility, nutrition or support at night. The person's needs were complex and we couldn't see how the provider had concluded that this support was not needed particularly when they were unwell due to their mental health.

There was a risk that staff were not providing the most appropriate care to people. One person had recently been admitted to the service. There was no care plan for them around what their needs were. The provider was basing their needs on an assessment undertaken by the local authority in 2012. The provider told us that they had discussions with the local authority and didn't feel that another assessment was needed. Another person had been re-admitted to the service recently and there was no current assessment of their needs. The provider told us that their needs had been based on the old care plan. The new manager told us that they intended to review and update all of the people's care plans as they felt that they were not detailed enough.

There were not enough activities taking place to meet the needs of people. One person told us "I'm lucky, I get to out (on their own), when I'm here there are no activities going on, there is a television and a radio here but I'm not fussed with that." Other people told us that they were bored. One told us "I would like to do some needlework." Another person said "I have just started going to a day centre, it was alright."

On the day of the inspection there was no evidence of meaningful activities on offer specific to the needs of people. There were long periods of time where people had no meaningful engagement with staff. One member of staff told us "I can't remember the last time I did activities with them (people)." They told us that when they had taken people out it was only for a walk to the shops or to see if there was anything on at the local centre in town.

The provider showed us a list of activities that had taken place. These activities were not always age appropriate and had not changed since the last inspection in September 2015. The activities recorded included a word game, out for walks and sessions where people reviewed the newspaper. There was a wide

age range of people at the service and there was no evidence that people were encouraged to pursue activities outside of the service. We did see the provider ask two people if they wanted to go to the day centre but one person told us that this was normally only available for four people at a time because of the space in the provider's car. Another person did say that they were happy just to sit and do things on their own.

Care and treatment was not always provided that met people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a complaints procedure which was placed in reception in place however the people that we spoke to about this didn't always know how to access it. The policy had not been reviewed since 2012. There was no evidence that people were spoken to about how they could make a complaint and one person told us that this wasn't discussed at residents meetings or with on a one to one basis. One person told us "I suppose there is a complaints policy, I wouldn't know but I would feel confident making a complaint." We saw that the last complaint was in 2015 and that this was still being addressed by the provider. There were other concerns raised by people in the service that had not been recorded as complaints.

As complaints were not always responded to in an appropriate way this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to how the service was managed and the quality monitoring processes that were undertaken. The provider submitted an action plan in October 2015 to state they had met the legal requirements. We found at this inspection that the registered provider had not made the required improvements to ensure the service was well led.

The service was not well led. There was a lack of leadership at the service which impacted on the care and treatment people received. The provider had failed to ensure that effective management systems were in place to assess, monitor and improve the quality of service people received. A new manager had been appointed and had only been at the service a short time before the inspection. Since the last inspection the provider had been managing the service with the assistance from a consultant. We found on this inspection that improvements had still not been made. The provider told us that they relied upon the consultant to make the necessary improvements but the provider had not taken steps to ensure that this was actually being done. We had asked the provider to send us in regular action plans after the inspection in September 2015 to show what improvements had been undertaken. They told us that this was because they did not realise they still had to and also assumed that the consultant was sending them to us.

We asked the provider to show us what quality monitoring had been undertaken. They showed us evidence of a health and safety audit in December 2015 and January 2016. However these had not identified the lack of robust window restrictors or any environmental concerns such as plugs not fitting sinks and ill-fitting doors. The provider told us that they relied up the inspection by the quality assurance team of Surrey County Council (SCC) to ascertain whether improvements needed to be made. The provider told us that aside from this no other quality checks were undertaken by them. The new manager told us that although they had been at the service a short time they had seen that improvements needed to be made but had not had the opportunity to address them. They said that they had identified that there were shortfalls around the care plans, meals; staffing levels and care of people needed improvement. We found that the provider was unable to locate records during the inspection. The records that were available were not always detailed and it was not always clear what care had taken place.

Although residents views had been sought these had not been used to improve the quality of care. Residents meetings were now taking place at the service. We saw minutes from the last meeting in which activities were discussed. People expressed interest in new activities such as gardening. However at the time of the inspection this had not yet been implemented.

The culture of staff and provider of the service meant that people were living in an institutionalised environment. One member of staff told us that they didn't feel supported there and although they were happy with the new manager this had not yet had an impact on the culture of staff. The provider told us "I have decided to change the culture";

On the day of the inspection we asked the provider for evidence of fire risk assessments. They were unable

to locate when the last inspection was undertaken or when the next fire safety inspection was due. They told us that they would have to provide this after the inspection as this could not be located on the day. We have not been provided with this evidence by the provider.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not effectively monitor what was happening in the service. 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. The provider had not informed the CQC of significant events. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.