Truecare Haven Support Ltd

# Norbury Crescent

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

This inspection took place on 7 September 2017 and was announced. We gave the provider 24 hours' notice to ensure they were available to facilitate our inspection. This was the first inspection of the service since it registered with us on 21 September 2016.

The service provides personal care and support for up to three people within a small care home setting, as well as providing personal care to people in their own homes. The service specialises in providing care to people who have learning disabilities and autism. There was one person using the care home service and one person using the homecare service.

There was a registered manager in place. 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.

Although we did not identify any medicines administration errors, people's medicines may not have been managed safely as the provider was unable to confirm the medicines stocks they should have in place. In addition, records relating to medicines were not always robust to reduce the risk of medicines being administered inappropriately. The provider did not always assess risks relating to people's care and ensure management plans were in place to guide staff in mitigating the risks.

The premises and equipment were managed safely in the main, although water safety was not managed well. The provider did not carry out checks of water temperatures to reduce the risk of scalding. In addition the provider did not have systems to reduce the risk of a Legionella bacterium accumulating in the water, in accordance with legal requirements. The provider confirmed they would take action to reduce these risks as soon as possible.

People were not always involved in planning their own care. The provider did not always ensure care plans were in place to guide staff in relation to all their needs.

The quality assurance processes in place required improvements as they had not identified the issues we found during our inspection.

People were safeguarded from abuse by the provider as staff understood their responsibilities in relation to this. Staff received training in safeguarding adults, from the provider.

People were supported by sufficient numbers of staff to meet their needs. The provider followed recruitment process so that only suitable staff worked with people.

Staff were well supported in their roles as the provider had a suitable programme of induction, training and

support and supervision in place. The support in place helped staff to understand and meet people's particular needs.

People were supported in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. Staff received training in the MCA and DoLS and understand their responsibilities in relation these.

People received a choice of food and drink and the right support in relation to their dietary needs. Staff also supported people to monitor and maintain their health and people had access to the healthcare professionals they needed.

People were supported by staff who were kind and treated them with respect. Staff understood the people they were working with including their needs and backgrounds and this information was recorded in care plans to guide staff in the best way to support people. Staff supported people to be as independent as they wanted to be and to take part in activities they were interested in. People were provided with information when they needed it, for example a person with autism had a visual schedule in place showing their programme of structured activities.

People, their relatives and staff were involved in the running of the care home. Healthcare professionals fed back to us that the service was particularly caring and well-led.

There was a suitable complaints system in place and the provider encouraged open communication so people could provide feedback on the service.

During this inspection we found breaches relating to safe care and treatment, person-centred care and good governance. You can see the action we told the provider to take at the back of the full version of this report.

## 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. People's medicines and risks relating to people's care were not always managed safely.

Although most aspects of the premises were managed safely, water safety required more systems in place.

People were safeguarded from abuse as staff understood their responsibilities in relation to this.

There were enough staff deployed to support people and staff were recruited through recruitment procedures to check they were safe to work with people.

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### Is the service effective?

**Good**

The service was effective. Staff received the right support in relation to training, support and supervision.

The service was meeting their responsibilities in relation to consent and the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People received a choice in relation to food and drink and were provided with the right support in relation to eating and drinking.

People were supported to maintain their health and staff helped them to access relevant healthcare professionals.

### Is the service caring?

**Good**

The service was caring. Staff knew the people they were supporting and understood their needs and preferences.

Staff treated people with dignity and respect, gave them the privacy they needed and supported people to be as independent as they wanted to be.

People received information at the right times.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive. People were not always involved in developing their care plans and care plans did not always reflect their preferences or guide staff appropriately in caring for them. However, people's care was regularly reviewed to check it met their needs.

People were offered a range of activities they were interested in when this was part of their care package.

There was a complaints system in place and the provider responded promptly to concerns raised.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led. The audits in place to check quality required improving as they had not identified the issues we found. The registered manager was completing a course to increase their knowledge of their responsibilities and staff had a good understanding of their role.

The registered manager encouraged open communication with people, relatives and staff.

# Norbury Crescent

**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.

The inspection took place on 7 September 2017 and was announced. We gave the provider 24 hours' notice to ensure they would be available to facilitate the inspection. It was carried out by a single inspector.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

During the inspection we observed how staff interacted with the people who used the service. We spoke with one person who used the care home service, two care workers and the registered manager. We looked at two people's care records, three staff recruitment files, medicines records and records relating to the management of the service.

After the inspection we contacted a relative of a person using the service via telephone and we also received feedback from two social workers via email.

Requires Improvement

# Is the service safe?

## Our findings

Although we received positive feedback about the way the provider managed people's medicines we identified some areas for improvement. A person told us staff administered their medicines on time and a relative told us there were no issues relating to how staff managed their family members' medicines. In addition, a social worker told us they checked the medicines records for the person receiving care in their own home and these were satisfactory with no omissions. We also did not identify any medicines administration errors.

However, the provider did not record the quantities of medicines received each month, or quantities of medicines carried over each month to keep track of stocks. This meant the provider had no way of verifying the medicines administration records were accurate by checking the quantities of medicines in stock were as expected. In addition the provider did not always record the prescriber's instructions on people's medicines records or details of allergies to ensure staff had ready access to this important information to reduce the risk of medicine being administered inappropriately, in line with best practice. Staff received training in medicines management and the provider told us they would introduce competency assessments to further reassure themselves staff administered medicines to people safely.

For the person receiving care in the care home the provider managed most risks to their safety well. The provider identified and assessed the risks to the person and put suitable management plans in place to reduce the risks. This meant staff had reliable information to follow in reducing risks to the person while providing care and support to them.
However, the provider had not assessed the risks relating to the person receiving care in their own home or put risk management plans in place. This meant the person, staff and others involved in their care may have been at risk and we could not confirm the provider was managing the risks well. These risks included those relating to the person's clinical needs, such as diabetes, diet and weight management and risks to staff, and others, of verbal and physical aggression towards staff. The provider had also not assessed risks relating to medicines management for any people using the service, in line with national guidance, which meant they could not be reassured they were mitigating the risks safely. The registered manager told us they would put the lacking risk assessments in place as soon as possible. After the inspection they sent us a risk assessment for a person relating to behaviour which challenged the service, and indicated they would further develop the management plan to guide staff in managing the person's behaviour.

The premises and equipment were managed safely in the main, although water safety was not managed well. A person told us, "If there was a fire I'd go outside. We have lots of practices". The registered manager ensured weekly checks of the fire alarm were carried out, with monthly checks of the health and safety of the environment. The provider had a contract in place for suitably qualified professionals to check the safety of the fire system periodically. Records showed electrical installation, electrical appliances and gas systems were safe. However, the provider had not followed national guidance for care homes to mitigate the risks relating to scalding by hot water and also Legionella. Legionella is a bacterium that can rapidly accumulate in water systems if risks are not well controlled and national guidance from the Health and Safety Executive (HSE) states a risk assessment and risk management plan carried out by a suitably qualified individual

should be in place. The provider told us they would improve systems relating to water safety as soon as possible and sent us evidence they had initiated checks of the water temperature a few days later.

These issues concerning medicines management, assessing risk and water safety formed a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider safeguarded people from abuse and neglect. A person told us, "I do feel safe here". Staff had a good understanding of the signs people may be being abused and how they should respond to suspected abuse to keep people safe. Staff received training in safeguarding adults at risk from the provider.

There were enough staff deployed to support people. A person using the service and a relative told us there were enough staff to support people. Staff also confirmed this, and the registered manager told us they never had difficulties covering shifts. We viewed rotas which also confirmed there were sufficient staff deployed to support people.

People were supported by a provider which followed recruitment procedures to reduce the risk of unsuitable staff working with them. These included checks of criminal records, references from former employees, health conditions which may require reasonable adjustments to the role, proof of address and the right to work in the UK. The provider obtained references from former employees although it was not always clear which employers these were from. The registered manager told us they would ensure the employers business was recorded on the references when we fed back our findings.

Good

# Is the service effective?

## Our findings

People were supported by staff who received appropriate induction, training and from the provider. The induction for all staff followed the Skills for Care 'Care Certificate'. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support. This meant staff reached the expected standards of care during their induction period. Staff received training in areas relevant to their role including learning disabilities and autism awareness, infection control and fire safety. Although staff had not received training in how to support a person with behaviour which challenged the service, this had been arranged with the CCG and was scheduled to take place. Staff were supported to complete diploma's in health and social care and the registered manager was completing the level 5 diploma in leadership and management. We identified staff did not receive training in diabetes awareness even though a person required staff to support them in relation to their diabetes. The registered manager told us they would add diabetes awareness to the training programme when we discussed this with them. Staff received monthly supervision with the registered manager where they reviewed the best ways to care for people and staff training needs. Hospital staff trained staff in how to use equipment to support a person remain safe while they slept.

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 were cared for by the provider in line with the MCA. A relative told us staff always sought permission before providing personal care to their family member. Our discussions with staff showed they understood their responsibilities to provider care for people in line with the MCA. The registered manager told us they had not carried out any formal mental capacity assessments to determine whether people could consent to their care as they believed both people had capacity. However, the provider had a policy in place to carry out mental capacity assessments and make decisions in people's interests when they were found to lack capacity, in line with the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had not applied for authorisations to deprive people of their liberty as they were not required, although they were aware of the process if they were required in the future. A person told us, "I'm free to leave anytime I want."

People were supported in relation to their dietary needs and preferences. A person confirmed they received their choice of food and they enjoyed the food they received. The person told us, "I get choices. For breakfast I like toast and scrambled egg with coffee." A relative told us staff followed guidance from a dietitian to

support their family member in relation to their specific dietary needs to maintain their health and their weight and a social worker confirmed this.

People were supported to access the healthcare services they needed. Records confirmed the person received support to access healthcare services including the GP, dentist and optician. The provider told us they would support the person receiving care in the care home to have a health action plan in place. This is a plan for people with learning disabilities to ensure their healthcare needs are identified and met which is usually developed and reviewed by a learning disability nurse. The provider also told us they would support the person to set up a hospital passport. This is a document which sets out the needs of a person with a learning disability to inform and guide hospital staff on how to support for them effectively. The person receiving care in their own home received support from a range of healthcare professionals, including daily support from a district nurse.

Good

# Is the service caring?

## Our findings

People were cared for by staff who were kind and cared about the people they supported. A person told us, "I'm very happy to be here". A social worker told us staff were "very, very kind and caring". Our observations of staff and discussions with them showed they enjoyed caring for the people using the service and treated them with respect. Staff spoke about people in a respectful way and also used respectful language when making records relating to their care. A staff member told us when a person wished to spend time alone in their room they understood their need for privacy. People's records were stored securely to ensure information about people remained confidential.

People were supported by staff who knew them well. A person told us, "Staff know lots of things about me." A relative told us there had been some issues with staff consistency but the provider had resolved these and the staff who worked with their family member now knew them well. Our discussions with staff showed they had a good understanding of people's needs, their preferences and backgrounds. A staff member told us they read the person's care plan and found out more about them by spending time with them. In the care home we observed staff provided care in a person-centred way. Staff were not rushed and spent as much time interacting with a person as the person wished. The person told us, "I love chatting, staff chat with me". Staff encouraged a person who was at risk of social isolation to spend time with them in communal areas and facilitated visits from family members to the service. The person told us, "My [family member] can come any time".

People were supported to be as independent as they wanted to be by staff. A person in the care home told us they wanted to be more independent. The person also told us, "I clean lots of things like tables and I put my clothes away myself". The person's care plan showed they had a programme in place to help them learn skills such as cooking, washing up, tidying their room and laundry. During our inspection we observed them doing tasks such as washing up themselves, and they proudly told us the tasks they were doing.

People were given information at the right times by the provider. For example, a person required structure and predictability to help reduce their anxiety and to meet their needs. The person showed us their weekly planner which set out how they would spend each day. They told us they had helped develop this planner and it was based on their interests. The planner reflected they would spend the day at a museum and this activity took place according to the planner. The person also had a weekly menu in place based on their preferences so they would know what meals they would be provided each day. The registered manager was also putting in place a visual rota so the person would be aware of which staff would support them each day.

Requires Improvement

# Is the service responsive?

## Our findings

People were not always involved in developing their care plans. One person receiving care in their own home did not have a care plan in place developed by the provider. The registered manager told us they followed the care plan which the CCG put in place and it had not been necessary to develop their own care plan. However, we identified the CCGs care plan was based on the person's clinical needs and did not set out the person's preferences for how they wished to receive their care, and there was no evidence the person had been involved in developing their care plan.

People's views on their care were gathered but not developed into a care plan to guide staff on how to care for them. After the inspection the registered manager forwarded us the pre-assessment they had completed before they began providing their package of care to the person receiving care in their own home. We saw the registered manager had gathered information from the person and a relative about how they wanted to receive care, including their interests and preferences. However, the provider had failed to develop this information into a care plan with the person at the centre of their care. This meant staff did not have any guidance to follow in providing care to the person according to their wishes.

In addition there was no guidance available for staff to follow in relation to supporting a person with behaviour which challenged the service, even though they had a history of such behaviour. This meant staff may not have been caring for the person in a way which met their needs and helped the person to remain calm.
This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The person receiving care in the care home was fully involved in developing their care package. The person told us, "There are lots of meetings. I like meetings with [staff and the registered manager]". They told us they met with staff to talk about their care and their care plan showed their care reflected their preferences. The person confirmed they were very happy with the way their care was provided to them. In addition their care plan contained sufficient detailed information to inform staff about their needs, background and preferences. Care plans covered all aspects of care the person required, including how to support them in the community to reduce their anxiety and to reduce feelings of frustration and anger. The registered manager told us they had been successful in supporting the person to feel more confident in the community. When they first began receiving care from the service the person required close physical contact with staff at all times when in the community as they felt afraid. The registered manager explained the person no longer felt afraid and told staff he no longer wished to have close physical contact. The registered manager also told us that, although the person had a history of behaviour which managed the service they had not had any such incidents since they began receiving care from the service. This indicated the service was providing care in response to their needs well.

People's care was regularly reviewed by the provider to ensure it continued to meet their needs. The six month placement review for the person receiving care in the care home was scheduled for October 2017. The person's social worker had held previous reviews which determined the placement was meeting the

person's needs. The people involved in caring for the person receiving care in their own home met monthly to discuss whether the care package was meeting the person's needs. These meetings included the person's relative, GP, social worker and a representative from the CCG. Minutes of these meetings showed there had been some issues which the provider was addressing. These issues included a high staff turnover which meant staff had not always responded to the persons needs well as they didn't always have a good understanding of how to care for the person. The person's relative told us the issue with staff turnover had improved and staff were now responding to their family member's needs well.

People were supported to do activities they were interested when this was part of their care package. A person told us, "I'm going to the museum today. It was my idea, I want to look around. I love museums". They also told us about the other activities they enjoyed each week including cinema, horse riding, pottery class, playing computer games and visiting the church.

The provider had a complaints process in place to investigate and respond to any complaints people made. The registered manager told us they had not received any formal complaints since they began providing care to people. However, a relative had raised a number of issues about the care their family member received. The relative told us the registered manager had responded well to concerns they had raised. Records confirmed the registered manager responded promptly to the concerns raised and carried out investigations.

Requires Improvement

# Is the service well-led?

## Our findings

People were supported by a service which was not always well led. Although the provider had some audits in place, including those relating to medicines management and health and safety, these had not identified the issues we found. The registered manage told us they carried out informal audits of all aspects of the service, including speaking with people and staff, but these were not recorded so we were unable to assess how satisfactory they were. Audits of medicines management in both the care home and homecare service were not well established. For the homecare service the registered manager told us sometimes staff took photos of the medicines records and sent them to them for audit, however the frequency this was carried out was irregular and the audits were not recorded. This meant people may be at risk of poor medicines practices.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they already planned to improve their medicines auditing systems when we raised our concerns and showed us various auditing templates they intended to implement.

People were provided a service by a registered manager who had a good understanding of their role in providing care to people using the service, but was not fully aware of the other requirements of their role. A person using the service and staff were complimentary about the registered manager. A person using the service told us, "I like it here, the manager and staff." The registered manager was not fully aware of the need to ensure people were involved in developing their care plans and ensuring risks were mitigated through a risk assessment process. The registered manager had a background in social care although they were new to running services regulated by CQC. The registered manager was completing a qualification in leadership and management of healthcare services to increase their understanding of their role.

The service had a clear structure in place. The registered manager was also the director of the service. They were supported by a deputy manager and a team of care workers. We found care workers had a good understanding of their role and responsibilities.

The provider encouraged open communication with people who used the service, relatives, health and social care professionals and staff. A relative told us the registered manager communicated well with them, keeping them up to date with their relative's welfare and were receptive to any issues they fed back. The registered manager often visited the person using the homecare service and met with others involved in their care each month as part of gathering their views on how the service could be improved. The registered manager also held regular staff meetings during which staff could feedback on the service. Care workers told us they felt well supported by the registered manager and they could contact them at any time for guidance. The provider monitored the support staff received well with matrixes in place to track staff training and support and supervision.

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 |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The care and treatment of people did not always reflect their preferences. Care was not always designed with a view to achieving people's preferences and ensuring their needs were met.<br><br>Regulation 9 (1)(c)(3)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care was not always provided in a safe way to people. The responsible person did not always assess the risks to the health and safety of people of receiving the care or treatment and do all that is reasonably practicable to mitigate the risks. The provider did not ensure the safe management of the premises. The provider also did not ensure the proper and safe management of medicines.<br><br>Regulation 12 (1)(2)(a)(b)(d)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems or processes were not established and operating effectively to enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. |

Regulation 17(1)(2)(a)