Care Quality Commission

Look Ahead Care and Support Limited

Haringey Respite Service

Inspection report

Flats 1 & 2 The Priory, 98 Priory Road, Haringey,
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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

Overall summary

This unannounced inspection took place on 29 December 2014.

Haringey Respite Service provides accommodation and care to people living in Haringey who have a learning disability. All the people using the service were young adults who lived with their families and came to Haringey Respite Service for respite care, to give them and their relatives a break or when their usual carer was unable to provide their care. The service is registered as a care home. Two people can use the service for respite care at any time as it consists of two adjacent one bedroom flats in the same block of flats. At the time of this inspection there was one person using the service.

The previous inspection was in June 2013 when the service had recently opened. At that inspection we found the service was meeting all the standards that we assessed.

There was no registered manager in the home. A registered manager is a person who is 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. The home has had two registered managers in the last year and a new manager started work in the service on 5

Summary of findings

December 2014, two weeks before this inspection. There had also been three changes of area manager. There has been a lack of continuity of management which led to the service not being as well managed.

There was a minimum of one staff on duty for each person using the service and two staff where people needed more support. Although there were sufficient numbers of staff on duty they did not always know people's needs well. A lack of continuity of staff could have a negative impact on the quality of the experience for people staying at the service. Relatives of the people who use the service were satisfied with some aspects of the service but one relative thought the service did not meet people's social needs and another thought personal care could be improved. Three relatives wanted there to be a consistent staff team who knew their son or daughter's needs as they had not always had this.

The environment was not safe. We found a number of maintenance issues which had not been addressed and risk assessments that had not been completed appropriately. The provider was also not carrying out effective health and safety checks in the service to help ensure people's safety.

The provider was not managing people's medicines safely. This was because the provider had not made arrangements for the safe recording and administration of people's prescribed medicines.

Relatives of people who used the service told us that their family member was happy to go to the service and were well looked after. They thought staff were kind and caring. Staff supported them with personal care, to make their own meals if they were able to, and to go out and do the things they liked to do.

Some people using the service had difficulty communicating their needs. Staff did not have enough training in communicating with people with a learning disability or autistic spectrum condition.

The provider was not monitoring the quality of the service or assessing safety risks regularly to ensure people received safe and good quality care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. Medicines were not managed safely. Therefore people were at risk of not receiving their prescribed medicines safely.

Staffing levels for the service were good but staff rosters were not always planned so that staff working had good knowledge of the people using the service.

The provider did not ensure the premises were appropriately maintained and was not monitoring health and safety matters in the home to ensure people's safety.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive appropriate training and supervision in 2014 so were not supported well enough for their role. There was a risk that people might not receive the care they needed as staff did not all have appropriate training.

Is the service caring?

Requires Improvement

The service was not always caring. Staff were kind to people and tried to get to know them and meet their needs but did not always know people's communication needs. The service met people's cultural and religious needs and encouraged people to be as independent as they were able to.

Is the service responsive?

Requires Improvement

The service was not always responsive. As only one or two people used the service at any time staff were able to personalise the service to suit each person including planning their choice of activities and menu for their stay. Staff supported people to follow their usual activities whilst they were using the service.

Support plans did not always reflect people's needs and abilities in enough detail to ensure staff could meet all their needs.

Complaints were not always recorded in sufficient detail to ensure the provider responded to the complainant.

Is the service well-led?

Inadequate

The service was not well led. The provider was not assessing the risks to people's health and safety nor monitoring the quality of the service effectively. The manager and area manager were new to the service and were making improvements.

Haringey Respite Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 December 2014 and was unannounced.

The inspection was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector visited the service and the expert-by-experience made telephone calls to families of people who used the service to seek their views.

Before the inspection, the provider completed 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 also considered the previous inspection report from June 2013, and notifications from the provider.

We spoke with three staff and the manager and carried out pathway tracking (where we read a person's care plan then checked to see if staff provided the care in accordance with the care plan). We observed four staff interacting with a person using the service and we reviewed records for eight staff to look at their training, recruitment and supervision records. We also looked at medicines and health and safety records.

We were not able to speak with any of the people who used the service due to their communication needs but we spoke with relatives of five people who used the service to find out their views on the care provided.

Inadequate

Is the service safe?

Our findings

Whilst the provider had some arrangements to safeguard people from the risks of abuse these were not always effective. Following a recent a safeguarding alert in relation to alleged financial abuse the provider said they would implement daily checks of people's personal money in the service. During our inspection we checked records of two people's money and these were not accurately completed to provide an audit trail as to how people's money had been spent. We also found that one person's personal money had been used to buy items which were not for their personal use without their consent or involvement of their relatives and which were the responsibility of the provider to buy. The internal financial auditing system and daily checks carried out by staff had not identified this matter so this could be rectified. The manager told us they would ensure this money was refunded to the person it belonged to.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding policy which staff read during their induction so they had the necessary information about the action to take to help ensure the safety of people. Staff had an adequate understanding of how to recognise and report any signs of abuse. Two staff had not received training in safeguarding adults but this was booked for a few weeks after the inspection. Staff were aware of different forms of abuse and procedures to follow. Staff said they would challenge any poor practice and abuse and would report any concerns to a senior person in the service.

The provider had a policy called 'Disclosing and raising major concerns Policy and Procedure' dated August 2013. This set out how a member of staff could report a concern. It also listed the relevant professional bodies to whom staff could go, including CQC, if they had concerns about how people were treated in this service.

We checked how the service managed medicines to ensure people received their prescribed medicines when they were staying there. We found only half the staff team had been trained in safe administration of medicines. Medicines were stored securely. There was no record of staff signing in the medicines that were being stored so there was no record of the amount of each medicine received. There was no medicines administration chart for staff to record when they had given medicine to the person using the service on the day of the inspection. One person had a prescribed cream and none of the staff on duty or the team leader from the previous day were able to tell us which part of the body the cream was to be applied. The previous day's care records stated that the cream was for one part of the body but staff had recorded in the person's file that they had applied cream to a different part of the body. Staff had recorded on the daily records that this cream needed to be applied three times a day but they had not done so. The medicine recorded on the "customer information sheet" (a document which has information about the person's needs) was spelled incorrectly.

We saw a medicines administration record for another person who had used the service recently. This recorded the prescribed medicines they had been given but had no dates recorded that staff had given it to the person. This lack of attention to accurate recording of people's medicines meant they were not protected from the risks associated with unsafe medicines management.

The above shows there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected both flats and found some safety concerns including a lack of maintenance of the premises. The bedroom light in flat 2 was not working, there was no emergency lighting and lights not working had been a recurring problem. Staff told us people had stayed in flat 2 with no bedroom light for four nights in the last week. The provider had reported this problem to the landlord five times in the last month but the problem had not been resolved. A bedside lamp was not suitable for some people staying in the service for safety reasons as they were not aware of the dangers associated with this, so the lack of an overhead light was unsafe as it left those people in the dark.

The provider did not have suitable arrangements to ensure people were protected from the risks associated with hot water. There was no plan in place to manage these risks. There were no thermostatic mixing valves fitted to ensure hot water at taps was within safe temperatures. Staff were

Is the service safe?

also not monitoring the water temperature to ensure this was within a safe range. The water was hot enough to cause scalding. In one person's care plan it stated that they were at risk of getting burned as they could not assess safe temperatures. The provider was aware of this risk but had not taken appropriate action to address this risk. They had put up signs saying, "Danger – very hot water" but this was not adequate as most people using the service were unable to read.

The provider had a monthly health and safety checklist which included testing the water temperature with a bath thermometer, however, this had not taken place. One staff member informed us staff had never tested the water temperatures and did not have a thermometer. There were no risk assessments in place or record of meeting with the landlord about resolving the water temperature problem. In January 2015, as a result of this inspection, the provider informed us that they had fitted thermostatic mixing valves to the sinks which control the water temperature, and purchased a thermometer immediately after the inspection.

Flat 1 had no toilet seat. Records showed the seat had been missing for four weeks. People had stayed in the flat and had to use a toilet with no seat. This did not ensure that people's dignity was maintained or they were protected from the risk of slipping and falling. We brought this to the provider's attention after the inspection and they informed us that they fitted a new toilet seat the following day.

There were some measures in regard to fire safety such as fire extinguishers and fire blankets. However other measures were not adequate. The fire risk assessment was dated January 2013 and had not been reviewed and was not complete. A fire door was not closing properly and no action had been taken to address this. People were not therefore fully protected in the event of a fire.

There was a lack of maintenance and health and safety checks in the service. Although kitchens and bathrooms were cleaned we found liquid spillage, dirt and hair on the floor in the communal areas. There were stains where a substance had been thrown onto the ceiling above the bed in flat 1 and stains on the walls in flat 2.

The concerns about the lighting, hot water, toilet seat, fire safety and cleanliness amounted to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service planned for emergencies. First aid kits were not stocked with the list of items needed and were therefore inadequate for dealing with emergencies. There was petty cash available to staff if they needed to buy emergency items people needed at short notice. However records showed that there was not enough money available to deal with emergencies and less than £1 on 11 days in the last month.

The service held contact details for GP, next of kin and emergency contacts for each person who used the service so they were able to contact the right people for advice in a health emergency.

Although the required number of staff were on duty, staffing of the service was not always planned in advance to meet the people's needs. Three of the five relatives we spoke with said there were changes of staff which was detrimental to the continuity of care. One relative told us, "there are regular staff changes… we just get used to one keyworker and then they leave." Another relative said, "Staff change quite a lot. They don't know my child well and so they don't have that good relationship with them to know what support they need." A third relative said they could not understand why the service did not use the same staff each time the person used the service, they told us "Staff keep changing and my [relative] doesn't accept help from strangers."

The manager told us that the changes in staff was because the staff team also worked at another service locally so the provider had to use a number of "bank" staff to supplement the permanent staff team. These staff were called Personal Support Assistants. Two of the four staff working during the inspection had not met the person using the service before. As many of the people using the service had communication difficulties it was important that staff working with them knew their needs otherwise this could have a negative impact on their experience using the service.

We looked at the personnel records for six staff for evidence of safe recruitment practices and found five files had two references on each file relevant to the job applied for. The sixth person whose recruitment records were not

Inadequate

Is the service safe?

satisfactory was no longer working for the provider. The provider informed us that all staff had criminal records checks which were clear. This helped to ensure staff were suitable people to work in social care.

The provider had a disciplinary policy and procedure which was comprehensive. They were following the policy with a staff member appropriately at the time of the inspection.

We recommend that the service finds out more about current best practice in relation to the staffing needs for people who have a learning disability.

Requires Improvement

Is the service effective?

Our findings

There were risks that people might not receive the care they needed because staff were not supported to carry out their roles. Four of the eight permanent staff did not have training in medicines handling even though this was a duty of all staff. Four staff did not have any specific training on learning disability, and none had been trained in personal care though this was booked for staff for January and February 2015. Four staff did not have training in first aid even though they worked alone at times. A lack of appropriate training meant that staff may not all be able to understand and meet the needs of people using the service.

We looked at how the provider supervised staff to ensure they were supported to deliver care safely and to an appropriate standard. We looked at six staff files and saw on one file that a team leader had completed a 'practice observation' of the staff member carrying out personal care and medicines administration two years previously. There was a comprehensive record of the team leader's observations. There were no other practice observations on the other five staff's files. The manager said that practice observation was the provider's policy and "should be done in between supervisions." This had not taken place which means the provider's policy was not implemented. We checked to see if staff received supervision sessions. One staff member had three supervision sessions in the past year, four had only one and one had none. The manager told us the provider's policy was for staff to have supervision sessions every six weeks. This had not been done. None of the staff had an appraisal in 2014.

The manager told us there was a five day core induction course for new staff which all staff had to complete before passing their probationary period. He said the induction also involved one month of shadowing an experienced member of staff and included working a variety of shifts to gain experience. Staff had an induction checklist with tasks they needed to achieve including reading the provider's policies. We saw training information for eight staff. One staff member had a qualification in health and social care. One staff member said the quality of training was good and helped them to understand the people who used the service. Six staff had attended refresher training on Autism, intensive interaction and managing challenging behaviour which were all relevant to the job.

The lack of suitable arrangements to ensure all staff had appropriate training and supervision to deliver care safely and to an appropriate standard means that the provider was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS are a code of practice to supplement the main Mental Capacity Act 2005. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The new manager had attended training on the MCA but none of the staff had been provided with this training. Some staff had knowledge of DoLS and the requirements of the MCA. We saw staff asking people for their consent before supporting them with their care. None of the people who used the service were subject to a deprivation of liberty safeguard. However, staff understanding was not supported by training from the provider in MCA and DoLS.

When people arrived at the service for their stay they planned a menu and a timetable of activities for their stay. People using the service were expected to bring their own food and drink as this was agreed with the local authority when the provider started the service and the provider only supplied breakfast. Alternatively they could bring money and staff supported them to go shopping for their food. This arrangement meant that people could eat food they liked. Some people using the service were not able to tell staff they were hungry. We saw one person sitting on the kitchen floor and staff recognised this as a sign that they were hungry. Staff responded to this appropriately by cooking the meal the person had brought with them.

Staff recorded dietary preferences in support plans, for example in one person's support plan it stated their religious preferences in relation to eating. Staff followed instructions from families on how to cook foods that met people's different cultural preferences.

The service had details for the GP for each person using the service so that they could make arrangements for people to seek health advice if needed but people's general health needs were met by their carers at home.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring because they had not taken prompt action where required to promote people's dignity and ensure their safety. Where there was no toilet seat the provider had not acted promptly to remedy the situation and had not always maintained the premises to ensure people were safe. Whilst staff were caring, the provider's arrangements for staff retention had not always enabled the development of caring relationships with people.

Relatives of four people using the service told us that they thought staff were caring and their family member was happy to use the service and spend time with the staff. One told us, " he is fine, we have no complaints" and another said, "Staff are nice. The ones I have met seem kind and caring." Another relative said, "I couldn't fault any of those staff."

We observed staff interaction with a person using the service. Whilst staff acted in a caring way, responding to the person's requests and using a calm friendly voice, the provider did not always ensure a consistency of staff to enable relationships to be developed between staff and people using the service. Some staff did not know the person's level of understanding because they had not met the person before and they were working alongside staff who did know the person's communication needs so their lack of knowledge did not have a negative impact on the person's experience using the service. If staff worked alone with a person they had not met before there was a risk of the person's needs not being met.

People's cultural, religious and personal preferences were met. The provider had a policy that staff of the same gender provide care to people using the service. We saw that where a person had two staff to support them, it was one of each gender. People were able to follow their religion and their cultural preferences when using the service. Staff supported one person to go to church when they stayed there. Staff cooked different cultural foods when families requested this.

We observed staff involving a person in making decisions about their care. Staff paid attention to detail such as making sure a person's coat was fastened because it was cold outside. They respected people's dignity by talking respectfully to them, asking them to do things rather than telling them and accepting people's rights to choose not to do what staff had asked. However staff did not always know how to best communicate with a person who was non-verbal and the information in their care plan was not comprehensive enough for staff to know the person's level of understanding.

Staff told us they gave a person privacy in the bathroom where it was safe to do so and waited outside to make sure they were safe. The provider encouraged people's independence by supporting them to cook their own food where they were able and willing to do so.

We recommend that the service seek advice and guidance from a reputable source, about current best practice in supporting people with a learning disability with communicating.

Requires Improvement

Is the service responsive?

Our findings

Staff assessed people's needs and planned their care when they arrived for their respite stay, including their meals and activities. The person using the service went out to a place they liked and was comfortable in the service.

We looked at some people's care plans to see if there was an up to date assessment of their needs and a clear plan for their care. We found that these included the person's interests, likes and dislikes and information about the support and care they needed. Care plans were reviewed regularly before each person's stay. The person using the service had a plan which had been written two weeks before our visit. However the information in the plan about the person's communication methods was different from what staff told us and what we observed, This lack of accurate information in the support plan put this person at risk of their communication needs not being known and met. We spoke to the manager about this who said they would review and update the care plan after seeking clarification from the person's family about their needs.

Three relatives said they were satisfied with the care provided when their relative used the service. Another said they thought the service was not designed to meet everyone's needs as people stayed there in isolation and some people preferred to mix with others to socialise when away from their family home. Another person said that staff did not give their relative good quality support with their personal hygiene. They thought the reason for this was changes in staff and lack of clear detailed guidance in the support plan.

We asked relatives about whether there was continuity of care in the transition between home and Haringey Respite Service. One relative said, "Communication is quite good but I have suggested they fill in a book/diary so I can keep up to date more." Another said, " yes [my son/daughter] is fine. I would just like more respite days". The manager said there was regular contact with day centres to share information about people's wellbeing and there was a plan to contact families more regularly to ensure they had opportunity to give their views on the care provided.

As each person using the service had one to one support from staff they were able to be supported in a way that suited them and plan their stay so that their individual needs and preferences were met. We saw that there was a programme of activities for the person using the service at the time of our inspection which had been planned with their relative and staff. Staff followed the agreed programme and supported the person to go to a local park and café.

In one flat we saw there were resources for activities for people, including a games console, DVDs, Lego, puzzles, nail polishes, beads, laptop and a football table. Some people brought their own things with them so they could continue with their personal interests while away from home.

The service had a complaints procedure which was also available in an easy read format with pictures to help people who could not read to understand it. The relatives we spoke with had not made complaints and said they knew how to raise concerns. We looked at the complaints record in the service. The manager said there had been some informal complaints, including about the missing toilet seat in flat 1, but these had not been recorded. We were therefore unable to get an accurate view of complaints about the service. A lack of recorded information about complaints meant the provider could not demonstrate they had investigated and responded fully to complaints.

We recommend that the service seek advice and guidance from a reputable source, about person centred care planning.

Inadequate

Is the service well-led?

Our findings

This home did not have a registered manager. There had been three different managers and three regional managers involved with the home in the last year. The new manager had started three weeks prior to the inspection and a new area manager started two weeks prior to the inspection. This lack of continuity of management meant that some staff had not received the training, support and supervision they needed in order for them to fulfil their roles to a good standard and to fully understand and meet people's needs.

Staff said the new manager was supportive. The provider had written an improvement plan for the service but this was written at the time of the inspection so it was too soon for us to see progress.

The provider failed to implement effective quality monitoring systems. Therefore, the provider was not aware that people were at risk of unsafe or inappropriate care. There had been only one quality monitoring visit in 2014 by the provider to carry out an audit of the service. As they had not been carrying out monitoring visits to the service they had not identified that some aspects of the service needed improvement. For example, staff were not carrying out health and safety checks properly. Hot water temperature was not being monitored and the monthly health and safety checklists recorded for seven consecutive months that the first aid box needed restocking but no action had been taken to replace the contents. There had been a failure to record and therefore monitor and act on complaints.

A survey sent to families in November 2014 had two responses. The provider told us that they were beginning weekly calls to families to seek their feedback on the service and planning a coffee morning for families to seek their views. There had been no relatives meetings or meetings for people who use the service in 2014. The provider had not regularly asked the views of people using the service, their relatives or staff working in the service in order to come to an informed view about the standard of care provided.

The fact that the provider did not have effective arrangements to assess risks to the health, safety and welfare of people using the service and others, and to monitor the quality of the service, including seeking the views of people using the service and staff, meant that they were in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15(1)(c)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with the unsafe management of medicines due to a lack of appropriate arrangements for the safe administration and recording of medicines. Regulation 12(1)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected against the risks of inappropriate or unsafe care as the provider did not regularly assess and monitor the quality of the service provided or identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 17(1)(2)(a)(b)(c)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Action we have told the provider to take

People who use services were not protected against the risk of theft, misuse or misappropriation of money as there were not suitable arrangements in place to safeguard against this risk. Regulation 13(1)(2)(3)(6).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have suitable arrangements in place to ensure staff had appropriate training and supervision to deliver care safely and to an appropriate standard. Regulation 18(2)(a).