Havilah Prospects Limited

Havilah Office

Inspection report

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25 October 2017

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 20 and 25 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service for adults and we needed to be sure that someone would be in. Havilah Office provides personal care to people living in their own home. The service provides care and support for people with disabilities and learning disabilities. At the time of our inspection there were two people receiving care.

There was a registered manager at the service at the time of our 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 and associated Regulations about how the service is run.

The last inspection took place in May 2017 when we rated the service as requires improvement, identified breaches of three regulations and served a warning notice in relation to safe care and treatment. This inspection was planned to follow up on whether the service had taken appropriate action to address our previous concerns. At this inspection we found that the service had not taken adequate action to become compliant with these regulations.

People were not protected from risks to their health and wellbeing because risks had not always been identified and existing assessments were not detailed enough to guide staff about how to manage specific risks. Staff did not know how to mitigate certain risks people faced. A relative told us that they had been required to explain to staff how to keep their family members safe while care was provided.

Care documentation was disorganised and was not reviewed on a regular basis. The information contained did not provide enough detail to enable newly allocated staff to provide person-centred care. People were at risk of not being supported to eat and drink enough because there was inadequate guidance about Percutaneous endoscopic gastrostomy feeding (PEG feeding) and there was no formal system to monitor people's weight where required.

Medicines were not managed safely. Accurate records about which medicines were given were not maintained. The management team did not know all the medicines that were being provided to people and protocols were not in place when medicines were provided on an as required basis.

Staff were not adequately trained to meet people's needs. Staff were not fully supported in their role by an adequate induction period, supervisions or appraisals. The provider could not be assured that people were suitable for working in the caring profession because they had not recorded the outcome from criminal record checks.

People were usually supported by their family to access healthcare professionals when they became unwell.

However, people were at risk of not maintaining their optimum health because staff did not know what to do in all emergency situations and did not know how to monitor people for signs of infection or deteriorating health.

The service was not organised in a way that promoted safe and quality care through effective monitoring systems. The service was not well led and there was not a clear management structure in place.

There were sufficient numbers of staff deployed to meet people's needs. People were treated with dignity and respect and a relative told us that the care staff worked well with their family members after a period of settling in. Some attempt was made at offering people choices about care tasks however this was not reflected in the care records. A relative told us they knew how to raise concerns if necessary though no formal complaints had been made since the last inspection.

The provider followed the latest guidance and legal developments about obtaining people's consent to care. People's relatives had signed care plans to indicate their involvement in care planning as appropriate.

We found five breaches of the regulations around training, safe care and treatment, person-centred care, good governance and meeting nutritional and hydration needs. Full information about CQC's regulatory response to any concerns found during inspections is added to the back of the full version of the reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore 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 timeframe.

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.

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.

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. Risks to people's health and wellbeing were not always identified and assessments did not provide enough guidance to staff about how to mitigate against them.

Medicines were not managed safely.

The recruitment procedure was not effective and did not ensure staff were suitable to work in the caring profession.

There were enough staff deployed to meet people's needs and staff had completed safeguarding training and understood how to recognise and report abuse.

Is the service effective?

Inadequate

The service was not effective. Staff had not received training and support relevant to their roles.

Staff did not always know how to support people to eat and drink in a safe way.

The service was working in line with the principles of the Mental Capacity Act (2005) and staff understood how to offer people choices about their care.

Is the service caring?

Requires Improvement

The service was not always caring. Care documentation did not include enough detail about people's likes and dislikes and methods of communication.

Staff had developed compassionate relationships with people and treated people with dignity and respect after a period of settling in.

It was reported that people did not have cultural or religious needs that needed to be met by care staff.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care documentation was

not always detailed or tailored to the individual to enable staff to carry out care in line with their preferences.

Care staff demonstrated that they knew people well.

Relatives were involved in care planning and felt confident they could raise concerns or their concerns would be listened to.

Is the service well-led?

Inadequate

The service was not well led. Monitoring systems were limited, incomplete and not fit for purpose and did not identify the concerns found during the inspection.

Communication methods for staff were not effective.

Havilah Office

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 20 and 25 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and staff are often out during the day; we needed to be sure that someone would be in.

Before the inspection we reviewed the information we held about the service. No statutory notifications about events that affected the service had been received.

The inspection was carried out by two inspectors. During the inspection we spoke with the registered manager and the operations manager. We looked at two people's care records, and three staff files, as well as records relating to the management of the service.

After the inspection we made telephone calls to one relative and one member of care staff.

Inadequate

Is the service safe?

Our findings

At the last inspection in May 2017 the service was not safe as risk assessments did not provide guidance to staff about how to manage potential risks particularly in relation to percutaneous endoscopic gastrostomy feeding (PEG feeding). The provider had not taken any steps to address these concerns and the issues remained.

People were not kept safe from harm due to risks to their health and wellbeing. The provider had not assessed all risks people faced and assessments available did not include comprehensive guidance for staff about how to mitigate identified risks. Documentation was not easy to navigate as archived risk assessments were filed with current risk assessments meaning it was unclear for staff to know which should be followed. One person required PEG feeding whereby all fluids, nutrition and medicines were administered via a tube through their abdomen. This process requires clear guidelines and protocols to ensure that it is completed safely. The provider had not drafted such guidelines as required following the previous inspection putting the person at continued risk of harm. The person's relative told us they had to explain how to administer PEG feeding, "I showed [the carers]. They were brand new people, now a little bit comfortable now I've shown them. It was difficult I show them everything." Staff we spoke with confirmed they were told how to use PEG feeding by the person's relative. We discussed our concerns with the registered manager who told us they had not produced any guidelines because the management were not familiar enough with PEG feeding protocols in order to guide staff. The registered manager confirmed that staff had not received PEG training.

This person had also been assessed as at risk from pressure ulcers and their assessment stated they needed to be repositioned at each visit and there was a requirement that care staff needed to report any issues with their skin to the management. However, there were no records in place to ensure the person was turned into a different position to relieve pressure. When we discussed our concerns with the management team they could not tell us whether or not there was a system in place to record repositioning but told us that there was a requirement to record this information. The person's skin had become red in September though the skin was reported as 'broken' in the daily logs. The management team were not aware of this deterioration or the lack of clarity in recording. The operations manager told us, "I haven't read [the daily logs]. They wouldn't necessarily report to the office as it's not life threatening. I haven't been informed." This failure to report was in contradiction to the requirement to report set out in the risk assessment and meant the risks of pressure damage had not been mitigated against.

A second person had been diagnosed with epilepsy. However, there was no corresponding risk assessment for staff to follow in the event of a seizure. Staff we spoke with could not adequately explain what they would do in such an event to keep the person safe or for them to receive the correct medical intervention.

At the last inspection in May 2017 the service was not safe as medicines were not managed in a safe way because there were inaccuracies around medicine recording. The provider had not taken adequate steps to address these concerns and the issues remained.

Medicine administration records (MARs) contained multiple errors because staff had not always signed them so it was not possible to tell whether medicines had been administered. The provider had not reviewed these records so no steps had been taken to assure themselves that people were receiving their medicines as prescribed. The provider could not be assured medicines were properly managed because there was no system in place to routinely collect and audit MARs.

Not all medicines that people took were in their care plans or on their MAR and it was evident from the daily logs that care staff were administering a medicine that was not known to the management team. People received medicine as required to manage their pain. This process requires clear protocols to enable staff to assess when such medicines were required and how to administer them safely. Care staff were not supported by written guidance about as required medicines and there was no information about side effects of specific medicines in people's care records. This meant people were at risk of unsafe medicines administration.

The issues above are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of potential abuse. People's relatives told us, "Yes, it is safe, I have no problem." Staff had received training in safeguarding adults from abuse but staff could not identify all types of abuse that people could experience. A member of care staff told us what action they would take. "There is physical abuse, sexual abuse, if someone is hitting them. I would inform my manager and call police if it is serious. I think they need to call to let the authority know, the social worker. I would call the number on the record book if they didn't do it." There was a safeguarding adults from abuse procedure for staff to follow but staff were not aware of it. They were not aware they should report the incident to the local authority safeguarding team or the Care Quality Commission if the provider did not take these steps.

People were at risk of harm because they did not have systems in place to ensure staff remained suitable to work in the caring profession. The provider had arranged for one member of care staff to undergo a second check via the Disclosure and Baring Service (DBS) in line with their policy to assess their suitability for work because four years had elapsed since their first check. However, they had not recorded the outcome of the check meaning they could not be assured the person was still suitable for working with vulnerable people. . The DBS is a check to see if prospective staff have any criminal convictions or are on any list that bars them from working with vulnerable adults. This meant the provider had not assured themselves that staff were suitable to provide care. However, their first check had showed no concerns. Relevant employment history, right to work, references and criminal record checks were available in the other staff file reviewed. The registered manager did not state they would address the issue.

There were enough staff deployed at the service to meet people's needs. The people's long-term carer had gone on leave and the provider had arranged for two additional care workers to be allocated to meet their needs. A family member was always present while care was provided meaning two people were always present to meet the people's needs. Staff told us they were able to contact the manager at any time, including out of standard working hours.

Inadequate

Is the service effective?

Our findings

Staff were not always provided with adequate training and support to meet people's care needs. A relative told us that care staff did not have the relevant knowledge to support their family members with percutaneous endoscopic gastrostomy feeding (PEG feeding) and using the hoist. We reviewed staff training certificates and noted that neither of the care staff had received epilepsy training or PEG feeding training which was necessary to them carrying out their roles safety. Neither had the necessary assessment regarding competency to administer medicines despite routinely administering medicines. The provider did not have a system to ensure that training was up to date and the management team were not aware of whether the care staff had received PEG training or not. When we discussed our concerns with the registered manager he recognised this was an unacceptable oversight. The registered manager said, "Yes, we should have that."

Two newly allocated care workers had begun to work with the people who use the service two months prior to the inspection. There was no formal handover to these new staff members from the previous long-term care worker and the management had not assured themselves they had up to date information about how people were supported. The management team had not conducted supervision sessions or spot checks on the newly appointed staff to assess whether they needed further training or support to meet people's needs. There was no annual appraisal on file for the long-term care worker so they had not had an opportunity to discuss their work or seek structured support. At the last inspection in May 2017 we had found staff had not received supervision required to perform their roles. This had not been addressed and staff had not received supervision by the time we inspected in October 2017. This meant the provider had not provided staff with the support they needed to perform their role.

The issues above relate to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure people were supported to eat and drink enough in a safe manner and in line with their preferences. One person's care plan stated that their weight must be monitored. There was no guidance for staff about how to do this or how frequently and there was no system to record their findings. There was no information about what weight loss was unsafe. Staff we spoke with were not aware they needed to monitor this person's weight.

One person required PEG feeding, however staff did not always record how much food and fluid was administered therefore putting the person at risk of not receiving sufficient nutrition or hydration.

One person's care plan provided very little information about what they liked to eat or any religious requirements. A member of care staff told us that the person was able to indicate whether they wanted to eat or not through body language but this was not captured in care documentation nor monitored by the care team. This meant that people were put at risk of not getting the food they wanted or to get enough food if they consistently refused to eat.

The issues above are a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to maintain their optimum health. People's health needs were mainly met by their family members and there was evidence that a nurse visited the people using the service. However, the management team were not aware of the full multi-disciplinary input into the people's care and multi-disciplinary treatment plans were not included during care planning, such as recording dietician input. Staff were not aware of all potential situations that may impact adversely on people's health and how to respond to an emergency, such as in the event of an epileptic seizure.

People's rights were protected as staff understood their responsibilities under the Mental Capacity Act 2005 (MCA). 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 can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications for this for domiciliary care agencies are made to the Court of Protection.

Staff tried to support people to live their lives in the way they chose. Care staff were aware that they were making decisions in people's best interests but still tried to ascertain what they wanted during day-to-day care tasks. We noted local authority assessments stated that decisions were to be made people's best interests. Relatives had signed their care records indicating their involvement in the best interests process as appropriate.

Requires Improvement

Is the service caring?

Our findings

Staff had developed caring relationships with people using the service. A relative told us that the two newly allocated members of care staff had begun to get to know their family members and were starting to work well with them. Staff we spoke with had fostered a good relationship with the people using the service and spoke warmly about them. Staff spoke positively about their work and explained they enjoyed the support they provided to people. A member of staff told us about the relationship they had developed with people who use the service, "When I wasn't there the [relative] says [person] will wait for me to come. They are recognising me now. I love it, I love the job I'm doing."

A relative told us staff knew how to communicate with their family member even though they did not communicate verbally. Staff we spoke with gave examples of how they communicate with people such as being attentive to people's facial expressions when giving people choices. Staff also explained that they were able to tell if people were in pain because of they would make a particular noise. A relative told us about how staff approached their role, "Yes they are talking to [my family members] while they do the work. They have begun that now at four weeks in. They had to learn how to do it. Their communication is now ok they are comfortable with both of them."

However, people's care records did not have clear communication plans including different methods for communication. Furthermore, one person had a visual impairment, however their care plan recorded their eye sight as good. There was no plan about how to best communicate with this person given their visual requirements.

People's diversity was respected. A relative told us that their family members did not have any particular cultural or religious needs. However, care records captured people's religion and care staff were aware of the general considerations they should afford people from that religion. It was recorded that food should be prepared in line with a person's religious requirements.

People's privacy and dignity was promoted. A relative told us they were happy with the privacy afforded to their loved one when they were supported with personal care. Staff took action to ensure this privacy, "If I want to change [person] I do not do it in front of the window and I have to cover them to protect their privacy." Care plans captured relationships that were significant to people so that care staff would know who was important to them.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in May 2017 we found the service was not responsive because people's care plans had not been fully reviewed to include personalised information about people's care. The provider had not taken action to make any improvements and the concerns remained at this inspection.

Assessments had been completed by the local authority which included information on people's mental, emotional and physical wellbeing, their interests and hobbies they enjoyed outside of the home, and the transitional arrangements were mapped from children to adult social care services to show how they moved between services. The provider had drafted care plans to be followed by staff when providing care for people using the service. These did not include key points to ensure that people received support that was person centred. This meant care staff could not be responsive to their needs. For example, information about a person's mental and physical health conditions was not included in their care records so staff were not aware of these needs.

Care staff we spoke with explained people's likes and dislikes, such as different music and toys they liked. However, this information was not included in care records and the newly allocated care staff had to learn about people's preferences over the period of a month.

Care documentation had not been reviewed or amended since our last inspection so no improvements had been made. One person had experienced a health concern and the care plan had not been updated to reflect this meaning care staff could not be responsive to the person's changing needs. Following the last inspection the provider submitted an action plan stating what actions they would undertake to generate improvements. The provider stated that an occupational therapist would review all care documentation and draft new care plans in order to properly meet people's needs. The management team confirmed that this had not happened so people's needs were still not being adequately met.

The provider had not done everything reasonably possible to support people and their relatives to provide feedback about the care provide following the change in care staff in September 2017. The last home visit and monitoring call had occurred in August so the provider had not given the opportunity for the relative to discuss any teething problems or larger concerns with the care provided by new care staff. The problems reported to us during the inspection were not known to the provider and the impetus to correct any errors fell on the family member themselves. The relative told us that they knew who to contact if they had any concerns and records showed that no formal complaints had been received since the last inspection.

The issues above are a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection in May 2017 we found a breach of the regulation in relation to good governance because the monitoring systems in place to assess the quality of care provided were not fit for purpose. The provider had not taken appropriate action to make improvements and the concerns remained at this inspection.

The service was not organised in a way that promoted safe care through effective quality monitoring. Monitoring systems were either non-existent or were inconsistently applied and ineffective and did not highlight the concerns we found during the inspection. For example, there was no system in place to audit medicine administration records or log books to check for errors in care and medicine administration. The problems we found during this inspection were not known to the management team. There was no training schedule to ensure staff received adequate training in epilepsy awareness and percutaneous endoscopic gastrostomy feeding (PEG feeding) in order to meet people's needs. Criminal records screening was not always conducted in line with the provider's policy. Despite making a commitment to the Care Quality Commission that care records would be reviewed and amended, the provider had not audited care records to assess the quality of risk assessments or level of personalisation contained, so none of the areas that needed improvement had been identified and addressed.

The provider had carried out one spot check at people's homes and once asked the family whether they were satisfied with the care plans since the last inspection. However, this was done prior to a change in care staff and the provider had not sought feedback about the service delivered since the changeover in order to seek out any developing issues in a timely fashion before they could impact on people's safety and wellbeing. As a result they had not been successful in identifying gaps in training knowledge which would hinder good care. The provider had not sought feedback from health and social care professionals or staff to drive forward improvements. Furthermore, the provider had not carried out an internal audit of the service to assess the quality of the service provided to people and compliance with relevant legislation and guidance in order to identify shortfalls and to draft an improvement plan. No improvement plan had been drafted in relation to the failings relating to risk assessments and medicine management found during the last inspection and no improvements had been made.

The service was run by the registered manager and an operations manager had been appointed since the last inspection. However, there was confusion between the two managers about who had responsibility for the day to day management of the service. The operations manager said that the registered manager did and the registered manager said the opposite and that they had not had any dealings with the operations of the service since a discussion with the operations manager two months prior to the inspection. A care worker we spoke with gave the name of a third person in addition to the operations manager when asked who their manager was. This meant no one was clear who was running the service. The two managers stated that the other had taken the lead in making the improvements required following the previous inspection and neither were able to clearly outline the plan they should have followed. This meant no one was driving forward improvements at the service.

Internal communication systems were poor. The provider had submitted an action plan to the CQC following the last inspection which stated they would ensure supervisions featured discussions around safety and they would be well documented. No supervisions sessions had taken place with care workers. No staff meetings had been held and there was no formal handover from the long-standing care staff to two newly allocated care staff members and no follow up sessions with the new staff to assess what support they needed in their roles.

The issues above are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.