The Camden Society

The Haven

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 2 and 4 December 2015. It was an unannounced inspection.

The Haven is registered to provide accommodation for up to five adults with learning disabilities who require personal care. At the time of the inspection there were five people living at the service.

The service did not have a registered manager. 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 service had management arrangements that included a service manager and a community support leader. The service manager had recently applied to be the registered manager and this application was now with the CQC.

People told us they felt safe and were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff had completed safeguarding

Summary of findings

training and understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse. However, staff did not always follow the homes internal safeguarding procedures.

People were not always protected from the risks associated with their care or the environment because thickeners were not always stored safely.

People received their medicines as prescribed and medicines were stored securely. However, there was no system in place to monitor the temperature of the room in which the medicine cabinet was situated.

Records showed that staff had been trained in The Mental Capacity Act (MCA). Some staff we spoke with had an understanding of the principles of the MCA. However staff we spoke with gave conflicting information about people's capacity. Care plans did not always contain clear information that was guided by the principles of the MCA relating to people's capacity to consent to care. People's care records did not contain information on how decisions had been arrived at or whether people may need applications made regarding Deprivation of Liberty safeguards (DoLS). Neither did records demonstrate the least restrictive option been identified and that this would be in the best interests of the people.

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. However, information used from these assessments to create care plans was not always accurate or up to date. Care records contained details of people's medical histories, allergies and on-going conditions. Care plans had been developed from the information people provided during the assessment process. However, peoples care records were not always completed to the same standard and some had information missing.

Accidents and incidents were documented and any actions were recorded. However, accident and incident forms were not always regularly audited to enable any trends or risks to be identified .

People's healthcare needs were regularly monitored. People had access to health care professionals where needed, such as doctors and specialists. Concerns about people's health had been followed up and there was evidence of this in people's care plans.

Throughout our visit we saw people were treated in a caring and kind way and staff were friendly, polite and respectful when providing support to people. Relatives we spoke with were complimentary about the care staff provided. Staff gave people the time to express their wishes and respected the decisions they made.

We observed there were enough staff to meet their needs. During the day we observed staff were not rushed in their duties and had time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support. People were supported to avoid social isolation by engaging in a range of meaningful activities.

Staff spoke positively about the provider and the managers and were confident the management team and organisation would support them if they raised a concern.

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we took and 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?
The service was not always safe.

People were supported by staff who could explain how they would recognise and report abuse. However, staff did not always follow the homes internal safeguarding procedures.

People were not always protected from the risks associated with their care or the environment.

People received their medicine as prescribed.

There were sufficient staff on duty to meet people's needs.

Requires improvement

Is the service effective?
The service was not always effective.

Records showed that staff had been trained in The Mental Capacity Act 2005 (MCA). However staff gave conflicting information about people's capacity.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities.

Requires improvement

Is the service caring?
The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefitted from caring relationships

Good

Is the service responsive?
The service was not always responsive.

Information used from assessments to create care plans was not always accurate or up to date.

People received personalised care. All the care plans held personal information about people including their care needs, likes, dislikes and preferences.

Requires improvement

Is the service well-led?
The service was not always well-led.

The provider had quality assurance audits in place. However, we had identified a safety issue for one client which had not been identified through these audits.

Accident and incident forms were not always regularly audited to enable any trends or risks to be identified.

Requires improvement

Summary of findings

Staff spoke positively about the provider and the managers.	

The Haven

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 checked whether the provider was 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 the on 2 and 4 December 2015 and was unannounced. The inspection was carried out by one inspector.

At the time of the inspection there were five people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

We spoke with four people, three relatives, five care staff, the service manager, the community support leader, the director of services and one healthcare professional. We reviewed five people's care files and records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns immediately to the manager. Comments included "I would document it and report it direct to manager or out of hours" and "I would go straight to my manager". Staff were also aware they could report externally if needed. Comments included "I would go to safeguarding, CQC (The care quality commission) or the police" and "I would go to safeguarding, police, GP and CQC".

However, staff did not always follow the homes internal safeguarding procedures. For example, one person who suffered from epilepsy was at risk of drowning during bathing. This person's care records stated 'Staff must not leave me alone', 'Baths are not recommended' and 'Risk of drowning'. When we spoke with one member of staff about the risk to this person they told us "We are with [person] all the time from the minute the plug goes in to the minute the plug comes out".

However, we observed from daily records there had recently been an incident when this person bathed alone. Although some staff were aware of this they had not reported this to the management team in order for actions to be taken to prevent this from happening again. This was not in line with the providers procedures in dealing with accidents and incidents. When we spoke with the service manager about this they were clearly concerned this had happened and they had not been informed. Comments included "It's the fact that I don't know about it" and "That's not good because around that time [person] was having seizures". We raised this with the provider who took immediate action by conducting an investigation and reporting the incident to the local safeguarding team and the CQC. Whilst the provider took immediate action to rectify the concerns we found the provider was unaware of the issues until we raised them. We have taken into account the action that the provider has taken and the timeframe of the incident and we are confident that the service will keep this person safe.

People were not always protected from the risk of choking. One person was prescribed thickener for their drinks. The thickener was not always stored safely. For example we observed the thickener was kept in communal cupboards along with other food and drinks. We raised this with the provider who took immediate action by removing the thickener from areas that were accessible to people.

Medicines were stored securely in a locked cabinet. However, there was no system in place to monitor the temperature of the room in which the medicine cabinet was situated. This meant that the service had no system to ensure that medicines were stored in line with manufacturer's guidelines. Staff were also unaware of what action to take if the temperature went above the required range. We spoke with the provider about this and they produced evidence this was being addressed.

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

People told us they felt safe. One person we spoke with told us "It is my home where I feel safe and happy." Relatives we spoke with told us "Oh yes [person] is safe, you can tell by how happy they are" and "[Person] is happy and believe me if [Person] is happy then she is safe and being looked after"

People received their medicines as prescribed. Staff administering medicines checked each person's identity and explained what was happening before giving people their medicine. This ensured people received the right medicine at the right time. Medicines administered 'as and when required' included protocols that identified when medicines should be administered. Staff had a clear understanding of the protocols and how to use them.

We observed there were enough staff to meet their needs. The service manager told us "The staffing levels meet people's needs". We observed and staffing rotas confirmed how the home had recently increased its staffing levels to mitigate the risk that one person may present if left alone. We spoke with the service manager about this and they told us "It was done to make sure [person] was not left unattended with other residents" and "I would rather go to my provider and explain my budget, than explain to safeguarding why people are not safe".

Staff told us there were enough staff to meet people's needs. Comments included "We are always fully covered", "We don't have any issues with staffing" and "If we did have a problem then we are very flexible as a staff team". One relative we spoke with told us "There were certainly enough staff the last time I visited".

Requires improvement

Is the service safe?

During the day we observed staff were not rushed in their duties and had time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support.

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identified if prospective staff had a criminal record or were barred from working with children or vulnerable people. We spoke with two new members of staff who told us "You are not allowed to work with service users until (background check) comes back" and "(Background check) had to be in place long before I started".

The home had personal evacuation plans in place for each person. This ensured people were protected during untoward events and emergencies. We spoke with staff who were aware of these plans and what action to take in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

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.

Records showed staff had been trained in MCA. Some staff we spoke with had an understanding of the principles of the MCA. Comments included: "It's about the best interest of the service user, it's about respecting choice", "You don't assume they don't have capacity just because of their learning disabilities" and "It's about best interests". However, staff were not always sure of people's capacity within the home.

Staff we spoke with gave conflicting information about people's capacity. For example, one member of staff told us one person had capacity, another member of staff told us and records confirmed the person did not have capacity in making decisions surrounding dental care. Another staff member we spoke with said "I guess they all lack capacity in some respect".

Care plans did not always contain clear information that was guided by the principles of the MCA relating to people's capacity to consent to care. For example, we were informed one person lacked capacity to make some decisions. However, there was no mental capacity assessment in this persons records to demonstrate this. This evidenced people's capacity to make decisions was not appropriately assessed or managed.

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

Deprivation of Liberty Safeguards (DoLS) provide legal safeguards for people who may be restricted of their liberty for their own safety. We saw the service had identified people who may need to be deprived of their liberty. However, at the time of our inspection no applications had been made to the supervisory body. People's care records did not contain information on how decisions had been arrived at or whether these people may need applications made. Neither did records demonstrate the least restrictive option been identified and that this would be in the best interests of the people.

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

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. Training included safeguarding, complex needs, moving and handling, epilepsy, infection control and health and safety. Staff comments included; "The trainings very good", "The training is good, we learn how to deliver good quality care", "The training is good, it teaches me to put good practice into my work" and "I did a lot of observation and training (during induction) and have just completed the first part of (national certificate)".

Staff received appropriate training to enable them to support the needs of individuals whose behaviour may challenge others. Staff received regular supervision and appraisals. Records showed staff also had access to development opportunities. For example, access to national qualifications.

Staff told us they found the supervision meetings useful and supportive. Comments included; "Supervision is good, we discuss good practice and areas for improvement" and "You have the opportunity to discuss what needs to improve and (The manager) listens and does something about it".

People had sufficient to eat and drink. People were invited to participate in the planning of menus on a Sunday for the rest of the week. We observed people were given a choice. We spoke with a staff member about this who told us "If they don't fancy it they have a choice, we treat them as we would want to be treated", "We use recipe cards to support people who find it hard to communicate" and "This is a sort of simple cookery book with the likes of our service users. The pictures are large and there are simple steps on how to make them. We look at it with each of our service users and let them choose what they want to eat and if necessary we will take them shopping. We do have a weekly menu to follow. We all try to sit together at tea time in the dining area, to eat and chat."

Requires improvement

Is the service effective?

People's healthcare needs were regularly monitored. People had access to health care professionals where needed, such as doctors and specialists. Concerns about people's health had been followed up and there was evidence of this in people's care plans. For example, one person who had reported a pain in their foot had been supported to make and attend an appointment with their G.P.

Good

Is the service caring?

Our findings

We observed people benefitted from caring relationships with the staff. For example, we observed staff noticed one person who was getting ready to go out had a unclean chin . The staff member gently wiped the person's face and supported them to put their coat on. We spoke with this person who told us "[staff member] looks after me .I like her".

We spoke with another person who told us "I like [staff member]" Staff confirmed the staff member they were talking about was one of the regular waking night staff. They told us "[staff member] is well thought of by the service users for their time and care of them." Relatives we spoke with told us "I can see a real positive change since [relative] has been in the service", "It's a homely environment with dedicated staff", "The staff are very caring", "The staff are good and caring towards [relative]" and "The staff are excellent".

Staff spoke with people in a warm, respectful and patient manner. Staff listened to what people were saying and gave them time to express themselves. Interactions were kind and caring. People were treated as individuals. For example, during our inspection a staff member dealt with a sensitive phone call from a relative following a seizure one person had the previous night. Straight after the call the member of staff went to the person's room crouched down to eye level and said "Your mum has just phoned and I have told her that you are now feeling better, is that o.k.?" The person had a big smile on their face and said "Thank you".

Staff treated people with dignity and compassion. When staff spoke about people to us or amongst themselves they were respectful. All the records we looked at used respectful language. Staff knocked on people's doors and waited to be invited in before entering. Where they were providing personal care, doors were closed. One staff member told us "Personal care is about communicating not exposing". One relative we spoke with told us "[Person] has limited communication, the staff really listen to (person's) needs. They have just had their hair done, they are looked after".

People had their own rooms which enabled them to maintain their privacy. Staff we spoke with told us people were encouraged to personalise their rooms. Every person's room had been personalised and made to look homely. One person told us "I love my room and these colours and I like the shelves with the sweets and my fleecy blanket on my bed. It makes me feel very happy in my home".

People were kept up to date with changes to the home. For example, the provider is planning on making significant changes to how it delivers its service and care in the future. We observed evidence that house meetings had taken place to keep people informed of the changes whilst seeking people's views and concerns. This was supported further by a newsletter which included a personalisation form that asked for people to highlight their preferences surrounding wall and floor coverings as well as electrical needs. Staff we spoke with told us "We have regular meetings to keep the service users up to date" and "It is important that we keep the service users up to date, but also get their views on the change".

Information relating to people and their care was held in the office. The office had a locked door ensuring people's information remained confidential.

Requires improvement

Is the service responsive?

Our findings

Care records contained details of people's medical histories, allergies and on-going conditions. Care plans had been developed from the information people provided during the assessment process. However, peoples care records were not always completed to the same standard and some had information missing. For example, one person who had health issues should have had a 'Health action plan' in their records. When we looked at this person's records the document was blank. This meant staff members who were unfamiliar with this person's needs would not be able to easily access important information.

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. However, information used from these assessments to create care plans was not always accurate or up to date. For example, one person who suffered from epilepsy had a care plan that stated the person liked to go swimming. We checked this with one member of staff who told us that "[Person] does not like swimming". This was confirmed in an assessment prior to admission that stated "Used to go swimming but does not wish to take this up again". This meant that accurate information was not kept within peoples care plans. We spoke with the service manager about this and they told us that this persons records would be updated and that there would be a further discussion with the staff team.

Most people received personalised care. All the care plans held personal information about people including their care needs, likes, dislikes and preferences. For example, one person's care plan highlighted how they enjoyed comedy, eating curry and going to the pub. We spoke with a member of staff about this who confirmed "[Person] loves a korma, loves slap stick comedy and the occasional lager and lime".

Care records included guidance on how to support people who may demonstrate behaviour that challenges others. For example, one person had a 'communication profile' in their care records that highlighted how behaviours may be misinterpreted by staff as well as what the behaviours actually mean. This also contained further information for staff to mitigate risk.

We saw evidence of how the service sought the advice from other professionals and took practical action. For example, the service had concerns surrounding a person's hoist as it was inaccessible from one side. The service requested the situation be assessed by a healthcare professional. Records showed that this assessment had taken place and the hoist was suitable to meet the person's needs.

People's care records demonstrated they were supported to avoid social isolation by engaging in a range of meaningful activities. For example, shopping trips, meals out and trips to the cinema. The planning of activities at the home was led by people with the support of staff. We observed people had a choice in activities. For example, on the day of our inspection two people were due to go out to the cinema. One person told staff "I don't want to go to the cinema. I want chips. I want to go out for a drive". The staff member asked the other person what they would like to do and they said they would like to do the same. Staff told the two people "If you would be happier to go for a drive and chips then let's do that".

The service had a complaints procedure displayed throughout the home. There had been one complaint since our last inspection this had been logged and responded to in line with the organisations policy.

Requires improvement

Is the service well-led?

Our findings

There was not a registered manager at the service. 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. Staff told us that this had an impact on service delivery. One staff member told us "It's because we haven't had a steady manager, things have slipped". We spoke with the director of services about this who told us that they had experienced difficulties recruiting to this post. However we observed that there were suitable arrangements in place that included a service manager and a community support leader. The service manager had recently applied to be the registered manager and this application was now with the CQC.

The provider had recently carried out a quality assurance audit and had identified concerns within the home. However, we had identified a safety issue for one client and an absence of applications for those people who may need to have their liberty deprived. Both of which had not been identified through these audits, therefore the system in place was not effective. We saw evidence where other issues had been identified in the home and these had been raised at a senior level within the organisation. An action plan had been developed that included key areas. For example, medication, MCA, care records, safeguarding procedures and the recruitment of a registered manager.

Accidents and incidents were documented and any actions were recorded. However, accident and incident forms were not always regularly audited to enable any trends or risks to be identified. For example, the service had not identified the incident were a person with epilepsy had taken a bath without staff supervision.

Staff and seniors told us that regular staff meetings were held. The service manager told us these were used to "To train staff and get feedback. Keep up to date with service users and be responsive to service users changing needs". Staff told us "We have regular team meetings" and "We have team meetings so we can get together and look at ideas for improving the service". However, these meetings were not always documented. The service manager told us that the frequency of these meetings was "Once monthly". However, the last record of staff meeting was in July 2015.

Staff spoke positively about the provider and the managers. Comments included; "They have really supported me", "We give the service users what they need and the provider looks after the staff", "The managers are really good they listen", "The managers look after us, we work together when we have a problem. They are approachable and supportive", "The managers are very good, they listen" and "They work with us they are approachable".

Staff were confident the management team and organisation would support them if they used the whistleblowing policy or raised a concern. Staff felt able to approach the service manager at any time for help and guidance. One member of staff said "The managers are good at supporting staff"

The service manager told us the visions and values of the home were "That people are treated with respected and that the service is person centred". It was evident from speaking with staff they shared the same visions and values.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The service manager of the home had informed the CQC of reportable events.

The service worked in partnership with visiting agencies, particularly the NHS and local authority. The service had links with local learning disability teams and with the local community. One visiting healthcare professional told us "The home is very cooperative, I have no concerns about peoples safety".

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not provided care and treatment in a safe way for service users.** **The provider had not taken reasonable steps to mitigate the risks to service users receiving care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not acted in accordance with the principles of the mental capacity act 2005 and associated code of practice.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not maintained accurate and complete records of all service users.**

This section is primarily information for the provider

Enforcement actions

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