Lifeways Community Care Limited

The Haven

Inspection report

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Date of inspection visit:
14 April 2022
21 April 2022

Date of publication:
28 June 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Haven is a residential care home providing personal care to up to five people. People were living with complex care needs relating to autism and learning disabilities. At the time of our inspection there were four people using the service. One of the four people lived in an annex to the building, but they also had access to the main building when they wanted.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the safe, effective, responsive and well led key questions the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
The service did not always support people to have the maximum possible choice, independence or have control over their own lives.

The service did not always review incidents when people were restrained, which meant that it was not possible to assess if the need for restraint could have been avoided or reduced. There was also no opportunity for staff to learn from these situations and improve practice.

Due to staff vacancies, meal choices, activities and goal planning had not been as actively promoted as they would have been if there was a full staff complement.

Right care:
The service did not have enough appropriately skilled staff to meet people's needs and keep them safe.

People's support plans gave conflicting advice to staff on how to promote people's wellbeing and enjoyment of life. Although there were some protections to ensure people's privacy balanced alongside their health needs, there were no policies or procedures in relation to this to safeguard people and staff.

Right culture:
Care was not always person centred and people were not empowered to influence the care and support they received. There was a tendency to do things a certain way because that was what had always been done. We could not be assured people's guidelines were followed or that when specialist support was needed this was always followed up. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

Despite the staff shortages, staff remained positive and felt supported. They felt the home was getting back on track and felt motivated to do the best they could for people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (Report published 9 September 2019) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. The service has now been rated requires improvement twice.

Why we inspected
This inspection was prompted by a review of the information we held about this service.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
For the key question not inspected, we used the rating awarded at the last inspection to calculate the overall rating. The overall rating for the service remains Requires Improvement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for the Haven on our website at www.cqc.org.uk

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to, Mental Capacity and a lack of person-centred care. We found continued breaches in relation to safety, staffing and good governance.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Haven

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we could understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
There was one inspector on the first day of inspection and two inspectors on the second day.

Service and service type
The Haven is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Haven is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and we wanted to be sure there would be people and staff at home to speak with us.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used information gathered as part of monitoring activity that took place in March 2022 to help plan the inspection and inform our judgements. As part of that process we sought feedback from people's relatives about the care their loved one's received. We reviewed the information we held about the service and the service provider, including the previous inspection report. We looked at notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection, we observed staff interacting with people to help us understand the experience of people living at the service. We spoke two staff, an agency staff member, the acting manager and area manager. We spent time reviewing records, which included two care plans. We looked at two staff files and documentation related to the management of the service such as accidents and incidents and medicines management.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at training data, care plans for two people, quality assurance records and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has stayed the same.
This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection the provider had not ensured the safe management of all medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 12.

- The provider could not be assured that people who needed 'as required' (PRN) medicines received them as prescribed.
- Whilst people's prescriptions were clear, the protocols that guided staff on when to use them were not always clear or accurate. This increased the risk people would be provided with inconsistent care and support.
- One person's protocol said that the tablet should be dissolved in water, but staff told us the person no longer needed a soluble tablet and that they now received this medicine in solid form. Another person received medicine in advance of specific personal care support, the medicine administration record (MAR), provided clear advice regarding when and how often it should be given. The protocol, however, was confusing in terms of the dose and frequency and did not define that it was only in relation to specific aspects of personal care. This left a risk that this medicine could be given inappropriately.
- One person received medicine in a dried format that was sprinkled on food. The support plan advised that the person did not always eat well, and staff should persevere in giving this to the person to ensure they received the full dose. Staff described how they ensured the person received the full dose of prescribed medicine. However, the technique used was not recorded and if not followed could leave the person at risk of not receiving their medicine.

The provider had not ensured the safe management of all medicines. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- By the second day of inspection the PRN for specific personal care had been clarified.
- There was a system for recording the temperature at which medicines were stored but we noted regular gaps in recording, and temperatures when taken, were always done between 8-9am. Varying the time at which temperatures are taken throughout the day will help to assess if there is a risk that some medicines (that required specific temperature storage) could degrade/become unstable.
- Medicines prescribed on a regular basis were given safely. Staff had received both online and face to face training in the management of medicines. In addition, they were assessed in terms of competency before

they were able to give medicines.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were not always well managed. People had positive behavioural support plans (PBS) but one person's plan had not been reviewed regularly. This meant the provider could not be assured their plan accurately reflect the person's needs.
● Some people were prescribed restrictive interventions (restraint) when they were particularly distressed or behaving in a certain way. We found two incidents where restrictive practices were used but these had not been reviewed by management. Records were poor and there was very limited analysis of what had led to incidents occurring and how they could be prevented from reoccurring. Only one of the six records seen included a debrief for staff. There was no oversight of the extent of injuries sustained by staff in the course of their duties and no evidence of any learning to minimise the risk of further incidents and keep people and staff safe from harm.
● It was not always clear how people should be supported. An agency staff member described the action they had taken to remove themselves from a situation they found challenging. We asked a permanent staff member what they would have done in this situation and they described a technique that was not prescribed or appropriate. The support plan gave conflicting advice in various places and stated staff should use the practice taught on PBS training. Agency staff had not received this training. This meant that people were at risk of receiving inconsistent, inappropriate and unsafe support from staff.
● The acting manager told us that all incidents were recorded. However, a staff member told us that although agency staff were encouraged to record incidents, this was not always done. This meant the system the provider used to maintain oversight of the frequency and type of incidents that occurred could not be relied upon.
● One person had been given PRN medicine for anxiety. The incident report and daily records lacked detail as to why the medicine was needed, how the person had been supported and who had authorised the giving of the medicine. This was also not recorded on the reverse of the MAR and did not enable the provider to reflect on the incident to ensure appropriate support was given. We asked the acting manager about one incident but they could not provide any further information.
● One person's support plan stated that if the person struggled to breathe during a seizure, emergency services should be called to make sure the person had enough oxygen. The acting manager told us an incident had occurred and they had not been able to get support from the emergency services. We asked if this had been discussed with the person's GP to see if any alternative plan could be arranged but it had not. This increased the risk that should a similar incident occur, the person might not receive safe and timely care or treatment.
● A staff member told us fire drills were carried out monthly, but people did not always comply with these. However, records of fire drills could not be located so we could not see how these were managed. Following the inspection, the provider advised that fire drills were meant to be carried out twice a year not monthly as stated. Due to high use of agency staff there was an increased risk that people and staff would not know what to do in the event of a fire.

The provider had not ensured care and treatment was provided in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person's needs in the event of a fire had been considered and each had an individual personal emergency evacuation plan that described the support they needed. There were systems to carry out regular health and safety checks including checks on gas and electrical appliances safety. Water temperatures were monitored regularly. A legionella risk assessment had been carried out to ensure the ongoing safety of water.

Staffing and recruitment

● There was not enough staff on duty who were suitably qualified to meet people's needs. There was a high number of staff vacancies and hours were covered through the use of overtime and agency staff. The acting manager told us that the assessed minimum staff numbers were six staff and the acting manager. Rotas showed that there were regularly four staff and that often the acting manager was included in staff numbers. This left the potential for people to be placed at risk of harm. The area manager acknowledged that staff levels were below what they should be and confirmed they were actively trying to recruit staff.

● Staff told us people did not always receive their one to one support in the afternoons due to insufficient staff levels. Two people required two to one support outside of the home and one required this level of support at the Haven by permanent staff who knew them well. Whilst permanent staff had received specialist training to meet people's needs, agency staff had not completed this training so this had an impact on the number and quality of activities that could be provided outside of the home.

● In addition to caring duties, staff also completed cleaning and cooking duties. Whilst a number of cleaning duties were carried out at night, there were still tasks to be done through the day. Staff told us they used times when people were settled, perhaps watching a film, to do these tasks and they carried a visual monitor to observe people. However, this meant people would not be receiving their one to one support; as assessed as necessary for them.

● Agency staff completed an induction to the service and received training via their agency. The provider was unable to assure us that agency staff were suitably qualified to meet people's needs. An agency staff member had completed all their training on one day. This included 15 subject areas. The area manager was not aware of this procedure and agreed to discuss expectations with the agency in terms of quality and quantity. An agency carer told us they had not received training on autism, and they asked us what autism meant.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The area manager told us that two staff had recently been appointed and we were told that five had recently applied for positions.

● We checked two staff records. All staff completed an application form and, references and identification were checked. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Please see the well led key question for more information.

Preventing and controlling infection

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Although the home appeared clean and hygienic, there were gaps in cleaning records which had been an ongoing issue that was being addressed with individual staff members.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The provider's infection control policy relating to hand hygiene did not refer to NICE (National Institute for Health and Care and Excellence) guidelines on infection control, that staff should have short unpainted nails to support hand washing. We saw that a number of staff had false or painted nails and were wearing jewellery. This could impact on the effectiveness of handwashing in reducing the risk and spread of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

The provider was facilitating visits for people living in the home in accordance with the current government guidance.

Systems and processes to safeguard people from the risk of abuse
● People were not able to tell us if they felt safe. We observed people to be relaxed and content in their surroundings. A professional told us, "I felt people were safe and there were enough staff." A staff member told us, "It's not unsafe, we are getting new staff and are using a new agency, and permanent staff have received training so it's getting better."
● Three people's relatives told us they felt their loved ones were safe. One commented, "I can sleep at night, knowing they are at The Haven."
● We asked a staff member about the reporting procedures for abuse and they gave a very clear response. All staff had received safeguarding training and knew how to recognise signs of abuse.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had not ensured staff had received appropriate support or supervision to enable them to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although this part of the regulation is now met, further time is needed to embed progress made into everyday practice. It should be noted that the home remains in breach of regulation 18 as other parts of the regulation are unmet. Please see the safe key question.

● Since the start of the year there were improved systems to ensure staff received ongoing support. Each staff member had only attended one supervision meeting this year but told us they were supported well in their roles. They had also attended at least one staff meeting and had daily handovers between each shift. One staff member told, "I do feel supported, I didn't at first, but the manager is very supportive and support from external managers has improved." Another staff member said, "If I have a problem I can speak freely, I've never felt I couldn't say what I wanted to. I've had regular supervision with (Manager)."
● Staff received a programme of training to ensure they could meet people's needs effectively. This included a mixture of e-Learning and classroom-based training. Essential training included safeguarding, moving and handling and infection control. Specialist training was also provided on subjects such as epilepsy, emergency medicines, autism awareness, Non-Abusive Psychological and Physical Interventions (NAPPI) training and PBS.
● Staff that were new to the service, were supported to complete induction training in accordance with current good practice. New staff shadowed experienced staff until they felt confident and their competence was assessed before they started to provide support independently.
● Agency staff completed an induction to the service and received training via their agency. See safe key question in relation to this.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff appeared to be risk averse and people at times had imposed restrictions without considering the least restrictive option. One person's trousers had been removed from their bedroom, so they only had shorts to wear. The acting manager told us they would be wearing shorts until Winter because the person was more likely to experience seizures when the weather was warm. This appeared to have been imposed by staff without specific evidence or guidance in relation to the person's choice, the weather and any risks.
● Three people had video monitors for surveillance when staff were not directly supporting them, 24 hours a day and this had been assessed as needed under DoLS. Staff told us this included when they used the bathroom and for private time. One staff member told us they felt uncomfortable viewing people at a time that would ordinarily be perceived as private. Information related to their use was conflicted in various sections of people's support plans. In addition, there was no overall procedure/policy on the subject to safeguard people and staff.
● One person's DoLS referred to audio rather than video monitoring. This was identified with the service during the inspection, so they sent an amendment request to the local authority.
● If people were watching a film in their bedrooms, staff carried the monitors with them so they could observe but also carry on with other tasks such as cleaning or cooking. This was not included in people's DoLS.
● Staff received training in the MCA and DoLS. Whilst they understood consent and the principles of decision-making, there was a tendency do things in a certain way because that was what had always been done rather than check with the person.

The provider had not acted at all times in accordance with the MCA and DoLS. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Best interest meetings had been carried out in relation to COVID 19 to ensure people's safety.
● Following our inspection, we wrote to the Nominated Individual (The nominated individual is responsible for supervising the management of the service on behalf of the provider) to ask them to arrange for the use of visual surveillance to be reviewed urgently. We also received a copy of video monitoring guidelines that had been introduced. We also received confirmation from the provider that they requested a review of one person's DoLS and as a result of this process no changes were needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals had been made for specialist advice and support when needed. However, it was not always clear when referrals were made, if advice was followed up and if appropriate reviewed.
● We saw reference to a referral that had been made to a speech and language therapist in 2020 for one person but it was not clear if this had happened or had been followed up. The home's action plan advised that this should be followed up. One staff member told us the person had difficulty swallowing and that their food was cut up for them. Other staff and records stated there were no risks with swallowing.
● The same person had a sensory assessment that had been carried out by an occupational therapist. There was no date on the guidelines, and it was not clear if the recommendations were being followed and the

person was receiving support to meet their sensory needs.
● One person had a specialist chair that was used for mealtimes. Staff presumed that a physiotherapist had prescribed the use of the chair but there was no information available to support this. Staff did not know when the use of the chair had last been reviewed to ensure it continued to meet the person's needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough to eat and drink. The acting manager told us that menus were written in line with people's known preferences. It was a set menu each day because people would always choose the same unhealthy foods, so they tried to provide a balance of choice and healthy options.
● Staff told us that if someone did not eat their meal an alternative would be provided. When this was the case one person was able to choose a meal from the freezer and another would write a note to staff to say what they would like instead. This person also had opportunities to buy food at the supermarket that would then be cooked at the Haven.
● One person had been assessed as at risk of choking, yet three people's food was cut up in bite size portions. We asked why this was done and the acting manager said that both people used plastic cutlery and it would be difficult for them to cut food with these. This had not been assessed by professionals to determine if this level of support was needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs, and wishes had been assessed to ensure they received appropriate care and support. These included various aspects of people's care needs such as how they communicated their preferences, and information on how they liked to spend their time. However, care files provided conflicting information in various sections. As the home had a high use of agency staff, this increased the risk that important information about people's needs was not easily accessible to those supporting people.
● The provider had identified in a recent audit that people's needs should be assessed.
● A relative told us, "They are transparent, upfront and allow us to view different reports that we ask for."

Adapting service, design, decoration to meet people's needs
● The Haven was designed to meet people's needs. One person lived in an annex to the building and three others lived in the main house. There was one vacant room. Communal areas consisted of a large lounge and a separate dining room. There was also a sensory (dark) room at the top of the house that two people liked to use regularly.
● Bedrooms had been personalised to fit in with people's tastes and personalities. Most had ensuite bathrooms.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person centred care. Care plans included conflicting and out of date information. One person's routine was very important to them. However, we saw several different versions of their routine in their care plan. As new and agency staff were supporting people in the service, it was important that care plans held up to date information about how best to support people according to their wishes.
- We were told that night staff made lunch for one person and when a second person was not at college for two people. We asked why this was done and were told that this was what had always happened and that it was one less task for day staff to do. This practice did not encourage or enable people to develop life skills. Following further discussion, the manager agreed that this was not in line with person centred care.
- One person's support plan stated they 'can walk independently but can be unsteady.' We saw that a physio had recommended the person walk bare feet in the house to strengthen their ankles. Staff were not aware if this was done. We asked how far the person could walk but none of the staff were able to tell us or what they should do if the person became too unsteady to walk when out.
- People were not supported to reach their goals. For example, one person's goal was to learn new skills in cooking and baking. Records showed that the person wanted to achieve this goal by July 2020. Staff told us this person was not involved in any meal preparation and daily records did not show that this person had been encouraged to do any cooking or baking.
- The shortage of staff who knew people well had an impact on the number and quality of activities that people could participate in. A staff member told us, "We try to get people out every day when we have enough staff and drivers, but we would like to be doing more with people. We go for a drive or a walk on the seafront. We get takeaway breakfast or lunch and go somewhere quiet to eat it. If we had more staff, we could do more."
- There was a sensory room referred to by staff as the 'dark room' for people to use. The room had a bed, blackout windows, a projector and a TV in it. People's daily records showed that this room was used but did not show what people did in the room or whether staff engaged with people in the room. One person had an assessment from the Occupational Therapist (OT) around the use of the dark room with specific activities for the person to engage in in this room. It was not clear from this person's daily records whether these recommendations had been followed.
- A staff member told us one person was choosing to spend a lot of time in their bedroom. They said, "It depends who is on shift." Records showed they had been out of the home once in 10 days. It was not always

clear from records if the person had been offered and refused activities and if they had been offered alternatives. The area manager told us the person was missing two staff that were not currently working in the home. They told us they would ask their PBS specialist to write a social story to help the person with emotional support.

The provider was not ensuring people received person-centred care. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw that one staff member spent time singing to and clapping with a person living at the home. The person seemed to enjoy this engagement and was happy to walk around with this staff member. This person went to college through the week.
● Relatives expressed satisfaction to how their loved ones were supported. One commented, "(Person) will sign to say that he wants to go home (which means The Haven)". Another relative said, "We regularly get emails, photos and videos to show what (Person) has been doing." A relative told us that the service was led by the service users and staff supported people to achieve what they wanted. They said their son had recently enjoyed a trip to London.
Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Permanent staff knew people well and how they communicated. Each person had their communication needs assessed and recorded. Records showed that staff used objects of reference to aid their communication with some people. Some had iPads. Staff told us that one person would take you by the hand to where they wanted to be. Another communicated with facial expressions, vocalisations and eye pointing.
● Staff told us that one person communicated in writing. They were able to express in this way when they were in pain, what they wanted to eat and any queries they had. For another person, staff knew that when they made a particular sound this meant they wanted some space and staff should give them time alone.

Improving care quality in response to complaints or concerns
● At the time of inspection, we were told that no formal complaints had been made to the service for a number of months. Previous complaints had been responded to in a timely manner.
● There was a detailed complaints procedure, and this was available in an easy read format that was displayed.
● Relatives told us they would raise any concerns with the staff, management or external agencies if required.

End of life care and support
● People living at the Haven were not able to express their wishes in relation to end of life care.
● The registered manager told us that if anyone needed end of life care in the future, this would be fully assessed with people's relatives and professionals involved in their care. In the interim staff had completed assessments based on people's known likes/dislikes and, where appropriate, relatives had been consulted for their views.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating of this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had not ensured good governance had been maintained to ensure systems were assessed, monitored and used to improve the quality and safety of the services provided. Not enough improvement had been made and the provider continued to be in breach of Regulation 17.

● The home had been without a registered manager since October 2021. They were actively recruiting for a new manager but to date this had been unsuccessful. The deputy manager had stepped into the role of acting manager but there was no acting deputy and only two of four team leaders. The acting manager was regularly working with people so had less time to work in the office.
● Although there were systems to monitor the running of the service, they were not always effective, and they had not identified many of the shortfalls we found on inspection. The organisation had carried out an extensive audit of the service in February 2022. The area manager confirmed weekly meetings were held to follow up on matters in the home's action plan. Whilst it was evident that several areas of the provider's action plan had and were being addressed, there was a lack of monitoring to ensure progress made had been sustained.
● Systems had not identified shortfalls in the management of PRN protocols. They had not identified that reporting of incidents were poor and lacked detail to assess what had happened, how incidents were managed and what learning had occurred. The action plan highlighted the shortage of staff but not the impact of the lack of permanent staff on outcomes for people.
● Whilst the action plan highlighted a number of shortfalls in care plans, some of which had been addressed, it did not sufficiently address the fact that folders were bulky, muddled and conflicting.
● There were a high number of staff vacancies and a high use of agency staff. Although the home tried to use regular agency, a lack of consistency, and agency staff that were not all fully trained to meet people's complex needs had the potential to cause impact on the support people received.
● Due to the quality of record keeping we could not be sure people's care plans were always appropriately followed or that they had enough activities to keep them stimulated. There was limited analysis of these documents to ensure appropriate person-centred care was provided.
● In relation to recruitment records we saw comments within one staff member's reference that raised a

question about the staff member's character but there was no evidence these had been followed up. The provider had not ensured good governance had been maintained to ensure systems were assessed monitored and used to improve the quality and safety of the services provided. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The area manager was visiting the home more regularly; the previous registered manager was working the in the home two days a week and another registered manager was also available for support two days a week either in person or virtually.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The acting manager was aware of the statutory Duty of Candour which aims to ensure providers are open, honest and transparent with people and others in relation to care and support.

● The acting manager was open and knowledgeable about the service, the needs of the people living there and where improvements were required. They understood their role and responsibilities to notify CQC about certain events and incidents. However, as we were not assured all incidents were recorded, we could not be sure that all matters that needed to be reported, had been.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There were systems to seek the views of staff and relatives. We saw records of staff meetings that had been held in December 2021 and February 2022. Minutes showed that staff were challenged on areas of concern or poor practice. Staff were encouraged to share their views.

● The last survey carried out to seek the views of relatives was done in November 2020. As part of our information gathering in advance of this inspection we spoke with relatives in March 2022. All expressed satisfaction to how their loved ones were supported. One commented, "(Person) will sign to say that he wants to go home (which means The Haven)." Another person said, "We regularly get emails, photos and videos to show what (Person) has been doing." Another person said, " Staff really do treat The Haven as (Person's) home, not their workplace."

● Staff were encouraged to complete an online survey. We were given a copy of the percentage outcomes for responses to questions but noted this related to the organisation rather than to the service.

Continuous learning and improving care; Working in partnership with others

● We received mixed feedback from professionals. One professional told us they felt they were dealing with too many different staff and some of the staff did not know about one person's needs such as in relation to personal care.

● Another professional told us, "Staff do struggle to engage with our team in general and we could chase quite a bit (be it initial assessments or on-going work). During on-site visits (staff) were always receptive to ideas etc. I think general care is good and management, but they struggle with more complex people."

● The area manager told us the acting manager attended regular manager's meetings for advice and support and that they had attended a regional meeting.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received person-centred support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure care and treatment must only be provider with appropriate consent

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 failed to assess risks and did not do all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Warning notice