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Sitara 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Sitara Haven is a care home for up to three adults with mental health needs. The service is run by an individual who also lives at the care home. At the time of our inspection there were three people living at the service.

People's experience of using this service and what we found
The provider did not always identify and assess possible risks in relation to a person's health and wellbeing. People received their medicines safely, but the staff were not always provided with adequate information which increased the risk to people. When an incident and accident occurred, it was not always recorded and investigated to identify any actions to reduce further risks.
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.
The provider did not have a robust quality assurance system to enable them to identify if action was required to make improvements.

People told us they felt safe and were happy at the home. Staff completed the training identified by the provider as mandatory and were supported in their role. People were supported to eat food they liked and encouraged to maintain a healthy diet. People were also supported to access healthcare and other service when required.

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 (published 25 March 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last five consecutive inspections. We issued a Warning Notice to the provider in relation to safe care and treatment requiring them to comply with the regulation by 30 April 2021. 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.

Why we inspected
We carried out an unannounced focused inspection of this service on 28 April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sitara 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 safe care and treatment, need for consent and good governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Sitara 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 can 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
The inspection was carried out by one inspector.

Service and service type
Sitara Haven is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The registered provider is an individual who is also the manager of the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We met all three people who lived at the service, the manager who is also provider) and observed one member of staff. We looked at a range of records including how medicines were being managed, the care records for all three people, records for staff recruitment, support and training and other records, which included checks and audits.

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 for this key question has remained requires improvement. 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 there was an increased risk associated with poor record keeping and storage arrangements for medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a Warning Notice to the provider requiring them to comply with the regulation by 30 April 2021.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• Staff were not provided with information on why people had been prescribed specific medicines. Risk assessments relating to medicines did not identify the specific consequences if these were not taken.
• Therefore, the staff were not provided with adequate information on how they could support people safely if an issue occurred in relation to the administration of the medicines.
• The medicines administration record (MAR) for one person indicated they were prescribed insulin, a medicine used to regulate blood sugar levels. The staff recorded the person's blood sugar levels twice a day at the time the insulin was administered. However, we found there was no information on what a normal blood sugar level or range would be for the person and what actions should be carried out if their blood sugar levels became too low or high. Therefore, this increased the risk of the person becoming unwell if their blood sugar levels fell outside the person's safe range.
• The policy for the administration of insulin indicated that following the checking of blood sugar levels the staff member should set the insulin pen at the required dosage before administering it. The manager confirmed the staff member administered a set dosage, no matter what the blood sugar level was, which had been identified by the specialist diabetes nurse. Therefore, the policy did not reflect how insulin was actually administered for the specific person. This meant the person could at risk of their insulin being administered incorrectly if the staff member was not familiar with the correct procedure.
• One medicine had a warning in relation to a possible risk if administered with a specific food type, but this warning had not been transferred to the person's medicines records, risk assessment or care plan. This meant there was a risk that if the person was offered the identified food type there could be a negative effect on the person's wellbeing.
• The manager explained they counted the number of tablets remaining when a medicine was provided in the original packaging, but this was not recorded so a stock level could be monitored.
• There was guidance for medicines which had been prescribed as 'PRN' - to be administered as and when

required, but we saw one person had been prescribed a medicine to support them with anxiety which was to be administered for a specific reason but there was no guidance for this. Also, the staff did not record the specific reason why a PRN medicine had been administered.
• One person had been prescribed an inhaler and used an aero chamber to administer this medicine. We found the aero chamber to be soiled and did not appear to have been cleaned in line with the manufacturer's instructions. The manager could not demonstrate the aero chamber had been cleaned which increased the risk of infection.
• Competency assessment of staff for the administration of medicines had been completed but these were very brief and did not cover the administration of insulin.

The provider did not ensure adequate information on medicines was provided to ensure they were administered in a safe manner. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The medicines were stored safely and securely. Medicines which required to be stored at a specific temperature were kept in a fridge which was only used for medicines. The fridge and the cabinet used to store the medicines were locked.
• The MAR chart used to record the administration of insulin stated that the injection should be administered on one side of the person's body in the morning and the other side for the afternoon injection to prevent the insulin being administered in the same place. Staff completed the MAR chart to show the insulin was administered twice a day.
• Training records indicated staff had completed training for the administration of medicines.

Assessing risk, safety monitoring and management
• At the last inspection we identified that risks had been assessed but there was a lack of detail on how these risks could be managed. We found the same issue during this inspection. For example, where a person had been identified as experiencing violent or inappropriate behaviour, the risk assessments indicated the use of one to one discussion, de-escalation or, if in the community, encouraging the person to return to the home by taxi. These measures did not provide any guidance on when staff should use these measures, what to do if they did not work and how to keep the person safe if they were in the community and a member of the public did not understand their behaviour. In relation to encouraging a person to get into a taxi to return to the home there was no information on what action should be taken if they refused and still experienced the behaviour. The lack of guidance meant that staff may not have provided support in a consistent manner to meet the persons needs and to ensure measures which may have previously escalated the situation were not used.
• Risk management plans had not been developed for issues relating to health and wellbeing. For example, we saw the care plan review for one person had identified a decrease in the person's mobility and other changes to their support needs, but the relevant risk assessments and management plans had not been developed.
• One person was prescribed a medicine used as a blood thinner, but a risk management plan had not been developed to provide staff with guidance explaining what they had to be aware of in relation to this medicine for example increased risk of bruising.
• The provider did not always ensure the emergency equipment in the home was ready for use. We looked at two fire extinguishers located in the communal areas of the home and these were marked as expired. The manager explained they had a fire equipment check carried out by an external company on 11 April 2022, but they had not been told about the expired equipment. We reviewed the report provided by the company which clearly stated the two fire extinguishers, and a fire blanket needed to be replaced. The manager explained they had not read the report following the safety visit and they would now ensure all the equipment was replaced.

The provider did not ensure staff were provided with guidance how to provide appropriate support to reduce identified risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The provider had not always recorded when an incident or accident had occurred and identified any lessons learned. The manager confirmed they had forms which could be completed but did not have a procedure for recording and investigating incidents and accidents.
• During the inspection we asked the manager if there had been any incidents or accidents at the home since the last inspection in January 2021. They informed us that there had been no incidents and accidents recorded in that period. Following the inspection, we looked at the care plan review for one person which indicated that two incidents and accidents had occurred during December 2021.
• Therefore, the manager was unable to demonstrate that these had been recorded and an investigation carried out to identify if anything could be learned to reduce the risk of reoccurrence. We also noted that the person's care plan and risk assessment had not been updated to reflect these incidents.

The provider did not ensure incidents and accidents were recorded and any lessons identified following an investigation were recorded to reduce possible future risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• The manager was not up to date on the current guidance in relation to the use of personal protective equipment (PPE). When we arrived at the home for the inspection the staff were not wearing face masks. We raised this with the manager who confirmed they were not aware of the current guidance and all staff immediately put on face masks.
• 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 accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• People were supported to be in contact with their family and friends which included visiting the home. When family and friends visited the home, the provider followed current COVID-19 guidance. People were also supported to visit local shops and take part in activities they enjoyed outside the home.

Staffing and recruitment
• The provider had enough staff to support people safely and meet their care needs. The home was mainly staffed by the manager and their family members. There were some additional staff who also provided support at the home.
• There was an appropriate process in place for the recruitment of new staff which included obtaining references and checking if the applicant had the right to work in the United Kingdom. Checks were made on any criminal records. 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.

Systems and processes to safeguard people from the risk of abuse
• There were systems to help safeguard people from abuse. Staff had completed safeguarding adults

training and the provider had developed a policy for the reporting and investigating of any safeguarding concerns.
• At the time of the inspection the manager confirmed there had been no safeguarding concerns or alerts raised. They confirmed one person had an advocate appointed for them, but they had not heard from them for a while. People's family members were in regular contact with them so they could raise any concerns they had with them.

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 inspection in May 2019 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

• The provider did not always ensure the principles of the MCA were followed and care was not always provided in the least restrictive way possible.
• The care plan for one person indicated that a DoLS had been applied for but we found the manager had not completed assessments of the person's capacity to consent to specific aspects of their care, for example support with personal care, COVID-19 vaccination and testing and the administration of medicines. Best interest decisions had not been completed to show how the decisions made in relation to providing care would benefit the person.
• The manager confirmed they managed the money for all three people using the service and the care plans stated staff should provide receipts from purchases. Financial transactions were recorded with receipts but there were no records to show the three people had consented for the manager to manage their money. Where a person may not have capacity to consent to this a mental capacity assessment and best interest decision should have been completed to ensure this was appropriate for the person.

The provider did not always ensure the principles of the MCA were followed so that people received appropriate support to make decisions about their care whenever possible. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

• There had not been any new admissions to the home for a number of years, but the provider carried out annual assessments and reviews on people's care and support needs.
• The reviews included information on any recent changes in the person's support needs, any achievements and any concerns which had been identified but we found care plans and risk assessments were not always updated to reflect any changes.

Staff support: induction, training, skills and experience
• Staff received the training identified as required by the provider. The manager explained this training included safeguarding, infection control, first aid and medicines administration.
• The training records we reviewed demonstrated all the staff were up to date with the provider's required training courses.
• Staff records showed appraisals had been carried and they received regular support from the provider.

Supporting people to eat and drink enough to maintain a balanced diet
• People were encouraged to eat a healthy diet which included food and drink they enjoyed. People we spoke with told us they enjoyed the meal options and we saw they were supported to choose what they wanted to eat. We saw they were supported to be involved in the preparation of meals if they wished.
• Care plan included information of people's food and drink preferences and if they were able to prepare their own meal or required support. Care plans also identified if the person required encouragement to eat a healthy diet or needed support for any other nutritional support needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access relevant healthcare services and other agencies to support their care needs. Care plans included general information on the person's physical and mental health needs.
• Records demonstrated people were supported to attend regular health appointments and to receive additional care when needed.
• The manager confirmed they worked with a range of healthcare professionals including district nurses, opticians and chiropodists.

Adapting service, design, decoration to meet people's needs
• The home had a comfortable, family like atmosphere. People were supported to personalise their bedrooms. There were two seating areas with enough space to enable people to either sit together or have time on their own if they wished. There was a dining area so people could eat together if they wanted and they could access a garden.
• People living at the home told they were happy living in the home, and they appeared relaxed and at home.

Inadequate

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 has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection, we found systems for monitoring and improving the quality of the service were not always operated effectively. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

• The provider had not made sustained improvements following a number of inspections. The location had been inspected on five previous occasions since 2016 and had been rated as required improvement following all of these inspections. The provider has not made the improvements required and the systems they used for monitoring and improving quality were still not robust enough.
• Issues with the management of medicines had been identified at the inspection carried out in 2018, 2019 and 2021. We had previously issued requirements and a warning notice requiring the provider to comply with the regulation by 30 April 2021. The provider submitted an action plan identifying how they would make improvements. At this inspection we found a continuing breach relating to the management of medicines which meant the provider had not taken appropriate action to make improvements.
• The provider's systems did not make sure checks were carried out to ensure if a person's consent was received for the care being provided or if best interests decisions were made and recorded when the person was unable to consent to aspects of their care.
• The provider did not have a robust system for the recording of incidents and identifying where lessons could be learned to reduce future risks.
• The provider's systems did not ensured staff were provided with adequate information on how to respond to and mitigate possible risks which had been identified.

The provider had not responded to the issues identified during previous inspections to make improvements to the quality assurance systems. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics
• People we spoke with told us they were very happy living at the home and the staff were kind and caring. The home had a family-based environment with a positive culture where people were encouraged and supported to be as independent as possible whilst ensuring they received the care they required. The people living at the home had lived there for a number of years, they got on with each other and the staff which was demonstrated by the family atmosphere.
• We saw the manager and staff had a good relationship with people living at the home and they had a good understanding of their needs.
• People were supported to provide feedback through regular meetings and discussion with staff.
• Care plans indicated who was important to each person and how to maintain contact with their family and friends. People were supported to access the local faith groups to meet their religious preferences.

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 provider had a range of policies and procedures in place which covered a range of issues relating to providing care at the home.
• The manager explained their responsibility to ensure they were open with the people and their relatives if things went wrong.

Working in partnership with others
• The provider worked in partnership with other organisations. The manager confirmed they worked with the local authority and mental health teams. They had developed links with local faith organisations. People were supported to visit the local Gurdwara and the home was visited by representatives of the local church.