Georgetown Care Limited

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Haven is a care home registered to provide accommodation and personal care for up to 12 people aged 65 and over. At the time of the inspection 10 people were living at the service, in one adapted building.

People's experience of using this service and what we found
People were not always supported to take the medicine they were prescribed. Staff did not always keep accurate records of medicines they supported people to take.

Risks to people were not always effectively assessed and managed. Action was not consistently taken following incidents to reduce the risk of a similar incident happening again. Systems to ensure the building was safe were not always implemented.

The provider did not have an infection prevention and control policy in place. Audits to check infection control procedures were being followed had not been completed.

The provider did not have effective systems in place to assess the quality of the service provided and make improvements where needed. The provider did not regularly visit the home to assess how it was operating. The manager had not completed some of the regular checks and audits that were needed for effective oversight of the service.

Staff demonstrated a good understanding of people's individual needs and a commitment to provide person-centred care.

People and their relatives felt they received good care and praised the staff. People felt safe living at The Haven. Relatives felt the manager had started to make improvements to the service.

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

Rating at last inspection
The last rating for this service was good (published 6 February 2021).

Why we inspected
The inspection was prompted in part due to concerns received about management of the service. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

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 we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, statutory notifications and management oversight and governance. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe 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 Care Act 2014.

Inspection team
The inspection team consisted of one inspector.

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

The service did not have a manager registered with the Care Quality Commission. It is a condition of the provider's registration that there must be a registered manager for this 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service and the service provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

During the inspection
We spoke with four people and three relatives to gather their views about the care they received.
We looked at three people's care records. We looked at a range of records about how the service was managed. We also spoke with the manager, deputy manager and two care staff.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke to two relatives and a health professional by phone.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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

- People were not always supported to take the medicines they had been prescribed and medicines records were not maintained accurately.
- Two people had not received their prescribed medicine for pain relief and constipation because the service had run out of stock. This had affected one person for nine days and the other person for six days. Another person had not received 14 doses of their medication during November. A fourth person had not received two doses of their prescribed medicine during November.
- Medicines for one person had been received into the service but not recorded. This meant the record of medicines held did not match the actual stock of medicines.
- Medicines administration records contained multiple gaps where staff had not recorded whether they had supported people to take their prescribed medicine. It was not always possible to say whether people had received their medicine.
- There were not always protocols in place to set out the circumstances in which the person should be supported to take 'as required' medicine. One person had received three doses of a sedative, prescribed to be taken 'as required'. There was no record of why this medicine had been administered or whether it had been effective.
- The manager said they had identified a number of shortfalls in the medicines management systems and were in the process of providing additional training for staff.

The provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;

- The risk of harm to people was not always effectively assessed, managed or reviewed following incidents.
- The manager reported staff did not always use the incident recording systems when there were incidents in which staff were injured. This included staff being hit, scratched and bitten when supporting people with their personal care. The lack of recording of these incidents meant there was not up to date information about the frequency of these incidents or reviews of systems in place to manage the risks.
- On the first day of the inspection one person had a movement sensor in their bedroom which was broken. The sensor was needed to alert staff if the person got out of bed, as there was a risk they may fall and be injured. The sensor was not consistently activated when we walked in front of it. The manager reported the sensor was replaced that evening, which we confirmed on the second day of the inspection.

● Risk assessments and plans to manage identified risks had not always been kept updated. The manager had identified changes that were needed; however, these changes had not been made at the time of the inspection. Examples included a falls risk assessment that stated it needed to be reviewed monthly but had not been reviewed since August 2021; and a pressure area risk assessment that had reviews scheduled for June and August 2021 which had not been completed.
● Systems to ensure the building was safe were not always implemented. Weekly checks of the fire alarm, firefighting equipment, call bells, window restrictors and hot water outlets had not been recorded since June 2021.

The provider had failed to consistently identify and assess risks so that action could be taken to keep people safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The manager was not able to find an infection control policy on the first day of the inspection. The provider had sent some policy documents to the manager for the second day of the inspection, but this did not include an infection prevention and control policy. The manager said they would obtain a new copy of the document so that it was available in the service.
● Although the home appeared clean and additional cleaning measures were in place, infection control audits had not been completed. The last recorded audit was in March 2021. There was no record that the provider was checking that procedures to protect people and staff were being implemented effectively.

The provider had failed to have effective systems to assess risks in relation to infection prevention and control. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● There were enough staff to meet people's needs. The manager had employed temporary staff through an agency to cover staff vacancies. This had ensured vacancies were covered by staff that had the opportunity to get to know people and provide consistent care to them.
● People and their relatives told us staff were available to provide support when people needed it.
● Staff told us there were enough staff at all times to meet people's needs safely.
● The manager had identified gaps in the recruitment records for some staff. Work was underway to obtain the missing information, including some references from previous employers and employment history. There was a record that the provider had obtained a disclosure and baring service (DBS) check for staff. DBS checks provide a record of any convictions and whether staff are barred from working in social care.

Systems and processes to safeguard people from the risk of abuse
● The service had effective safeguarding systems in place. Staff had a good understanding of what to do to make sure people were protected from harm.
● Staff were confident the manager would take action to keep people safe if they raised any concerns.
● Relatives told us they were confident people were safe in the home.

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 the last comprehensive inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. 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; Continuous learning and improving care

- The provider had not ensured incidents were reported to CQC when necessary. These are required to enable CQC to monitor how the service is managing incidents and whether the provider has taken appropriate action.
- Notifications had not been submitted for two people who had died at the service or for two incidents in which people sustained serious injuries. The manager confirmed no notifications had been submitted following these incidents. Our records confirmed no notifications had been received for these incidents.

The provider had failed to notify CQC of significant events in the service. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

- The provider did not have clear oversight of the service and had not implemented effective governance systems.
- There were no systems in place for regular assessment of the service by the provider. The manager said they were not required to send regular performance reports to the directors and directors did not regularly visit the service.
- No regular audits of the service were taking place. The manager said they were in the process of developing a system for regular audits of the service, but these had not yet been implemented.
- The service did not have a registered manager. The manager had been in post for approximately three months and had not submitted an application to register with CQC. The provider is required to have a registered manager at the service as a condition of their registration.

The provider had failed to have effective systems to assess, monitor and improve the quality of the service provided. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) 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; 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 manager said they had been working to change the culture of the service since they had been in post. They had supported staff to take on more responsibility in the service and to provide feedback on areas that

needed to improve.
● Staff demonstrated a good understanding of people's individual needs and a commitment to provide person-centred care.
● People and their relatives were positive about the culture in the service and the 'homely atmosphere'. Comments included "The manager has been very good. They have open and honest conversations with us" and "We are very happy with the personalised care provided, particularly at the end of life."
● The manager understood their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service involved people, their families, friends and others effectively in a meaningful way. The manager responded to issues raised and let people know what action they had taken.
● Relatives said they had regular contact with the manager, which enabled them to work together to meet people's needs. One relative commented, "The manager has been very easy to contact and discuss any issues with."

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had not ensured the Care Quality Commission was notified about the death of people who used the service. Regulation 16

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured the Care Quality Commission was notified about serious injuries to people who used the service. Regulation 18 (2)

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 ensured the proper and safe management of medicines or that risks to people were assessed and managed effectively, including risks relating to preventing and controlling the spread of infections. Regulation 12 (1) (2) (a) (b) (g) (h)

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 did not have effective systems to assess, monitor and improve the quality of the service provided. Regulation 17 (1) (2) (a)

The enforcement action we took:

We served a warning notice.