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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 7 March 2018 and was unannounced. The last inspection took place in March 2017 and the service was rated 'requires improvement' in Safe, Effective, Well Led and overall but we did not find any breaches in relation to the Regulations. Caring and Responsive were rated 'good'. During this inspection, we found that improvements had been made on the areas identified at the last inspection but further improvements were required. We have rated the service 'requires improvement' in the key questions of Safe, Effective, Responsive, Well-Led and overall.

Sitara Haven is a 'care home' for up to three people with learning disabilities. 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. At the time of the inspection, three people were using the service.

The person who owns the home is registered as an individual and manages the home. Therefore the home does not require a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found people had risk assessments and management plans in place to minimise risks and incidents. These were reviewed annually but the risk management plans were not updated to show there was an evaluation of the risks people faced and the effectiveness of the management plans to mitigate the risks

Care workers followed procedures for the management of people's medicines and underwent medicines training. Medicines audits were in place. Care workers had completed medicines competency testing but it was not clear what this involved and it did not include administering insulin injections. Therefore we could not be sure people were receiving their medicines safely as prescribed.

The provider did not always comply with Mental Capacity Act (2005) principles as an application for a Deprivation of Liberty Safeguards authorisation was not applied for. However we saw care workers were responsive to people's individual needs and preferences. Additionally there was no indication that people's end of life wishes had been considered as part of the care planning and consent forms were not fully completed.

Care plans were reviewed annually and involved people using the service but the paperwork was not up to date, so we could not be sure peoples' current situation and preferences were recorded. In addition, the language used in the care plans was not always person centred.

The provider did not have effective quality assurance procedures as checks and audits did not identify

concerns highlighted in the inspection.

We found four breaches of Regulations during the inspection. These were in respect of safe care and treatment, consent to care, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

People's rights to make decisions were not always respected and their independence was not always promoted.

The provider had procedures in place to protect people from abuse. Care workers we spoke with knew how to respond to safeguarding concerns.

Care workers had completed training in health and safety and used protective equipment as required.

Care workers had up to date relevant training, supervision and annual appraisals to develop the necessary skills to support people using the service. Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

People indicated they were happy at the service and care workers knew peoples' likes and dislikes and what their routines were. Families were welcome to visit.

People's dietary and health needs had been assessed and recorded and were monitored to make sure their nutritional needs were met.

The staff worked with other agencies, such as healthcare teams, to make sure people's needs were being met and people had access to medical services when needed.

There was a complaints procedure in place, however the service had not had any complaints since the last inspection. People using the service and care workers felt the manager listened to their concerns.

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.

Risk assessments were reviewed annually but the risk management plans were not updated and contemporaneous.

Staff competencies to administer all medicines had not been undertaken to make sure people received their medicines as safely as possible.

Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

The care workers knew how to respond to safeguarding concerns.

There was a procedure in place for the management of incidents and accidents.

The provider had an infection control policy in place and the care workers understood the risks around the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always followed.

Care workers were supported to develop professionally through training, supervision and yearly appraisals.

People's dietary and health needs had been assessed and recorded and were monitored.

The home's environment met the needs of the people using the service.

Is the service caring?

Requires Improvement

The service was not always caring.

People said the care workers treated them kindly and with respect.

People were involved in making some decisions about their care. However their right to make decisions was not always respected or their independence promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were reviewed annually and people were involved in planning their care, but care plans were not updated and contemporaneous so that they reflected people's current needs and interests. In addition the language used was not always person centred.

The provider had not had any complaints but had a procedure in place to follow.

The provider said they had end of life wishes recorded but they did not show us evidence of this.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had data management and audit systems in place to monitor the quality of the care provided. However these systems and checks were not effective in improving the quality of the service people received.

People using the service and the care workers had the opportunity to provide feedback to the provider.

People and the care workers told us they could approach the provider to share their views and discuss their concerns and the provider listened.

Sitara Haven

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 March 2018 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's learning disability team and safeguarding team to gather information about their experience of the service.

During the inspection we spoke with three people using the service, the provider and two care workers. We viewed the care records of three people using the service and three care workers files that included recruitment, supervision and appraisal records. We looked at training records for all five care workers. We also looked at medicines management for three people who used the service and records relating to the management of the service including service checks and audits. After the inspection we spoke with two relatives and a healthcare professional.

Requires Improvement

Is the service safe?

Our findings

At the inspection on 21 March 2017, we recommended that the provider develop systems in line with the Royal Pharmaceutical Society guidance on the management of medicines in care homes to ensure the proper and safe management of medicines at all times. At this inspection we saw the provider had made some improvement to how they managed medicines, but not enough to make this process safer for people.

Since the last inspection, one person had begun receiving insulin injections. The provider said a nurse had shown the relevant staff how to give the injections but we did not see any written guidelines for administering insulin, action to take in relation to any complications that can arise when administering insulin or confirmation staff were competent in administering insulin. The provider told us they would write up guidelines and planned further training in March 2018.

During the inspection we saw people had risk assessments attached to the relevant section of the care plan, for example healthy eating or smoking. However the risk assessments we viewed were not robust as the evidence of the review of the risk assessment taking place was a record of the date. There was no updated evaluation of the risks people faced and the effectiveness of the management plans to mitigate the risks. The risk plans we saw were dated 2013 and 2014. One person's risk plan dated 24 March 2014, for health and safety, stated that the risks the person was unaware of were health and safety risks. The action to mitigate the risk was 'train to use kitchen appliances' and 'train to put out cigarettes and empty ashtrays properly.' The plan did not have details of how the person would be supported with these tasks and showed no progression in the four years since the risk assessment had been written, although a separate page recorded an annual review had taken place. This meant we could not be sure risk management plans reflected people's current needs.

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

We looked at medicines administration records (MARs) and reconciled medicines for three people. There was a staff signature sheet to identify who had initialled the MAR charts. Only three staff administered medicines. They were using only one initial and we advised they should use two to clearly show who administered the medicines. Medicines were on a seven day cycle from the pharmacist and no extra stock was held. Medicines were stored safely in locked cupboards at the correct temperature. The provider had a medicines policy and a PRN (as required) policy on a separate page which had handwritten notes on the back that it was reviewed in December 2017. No one was currently receiving PRN medicines. The provider was completing weekly audits and stock takes.

Notwithstanding, care workers did not have records of the competency assessments to carry out the injection of medicines, they had completed annual medicines training and we saw a chart that indicated staff who administered medicines had been 'assessed as competent in handling medicines, the safe administration and disposal of medicines, safekeeping and recording'. The provider said people were observed for the assessment but the record did not indicate this. The provider agreed to clarify the records.

The provider had a business continuity plan that had handwritten on the back 'implemented 31 January 2018'. They also had safeguarding and whistleblowing policies but these had not been updated. For example the safeguarding policy described seven indicators of abuse, although current guidance includes ten indicators of abuse. The local authority's contact number was handwritten on the policy.

People and their relatives said they felt the home provided a safe environment. The provider had not raised any safeguarding alerts in the last year but said they were aware of their responsibility to inform the Care Quality Commission (CQC) and the local authority of any safeguarding concerns.

Care workers had undertaken safeguarding training in the last year and those we spoke with were able to identify the types of abuse and knew how to respond to safeguarding concerns. They told us, "Safeguarding report it to the manager and police and health care coordinator and do an accident report" and "Firstly I report it to the manager and if no action then I report it to social services and CQC."

The provider's procedures included information on how to manage incidents and accidents. One care worker said, "If there is any accident in the home, do first aid and call an ambulance and the first priority is it is safe for the residents." The policy on 'protection of service users' included the home policy on protection, service user monies and finance, violence in the workplace and training and recruitment and provide staff with guidance on how to mitigate potential harm to people using the service and staff.

General risk assessments for the home were completed years ago but had dates for current reviews and included call bells, showering, personal care, control of substances hazardous to health and smoking. The smoking risk assessment dated July 2007 stated the measure put in place to mitigate the risk of fire was smoking was 'permitted in dining room when other people who don't smoke not there and only with staff supervision and support otherwise only in the garden.' Two of the three people using the service smoked and during the inspection we observed they only smoked in the garden. Each person had a personal emergency evacuation plan (PEEP) that provided guidance on what do in the event of a fire.

The provider had a finance policy and systems were in place for the safe management of people's money. People's money was stored securely. Each person had a separate finance book that recorded their benefits and expenditure with receipts included. We saw one person's account did not match the money in their cash tin by a small amount. The provider agreed to do a monthly reconciliation of finance books to ensure money was audited and managed safely.

The service was a family run business and the family lived on the premises with the people using the service. In addition there were two other care workers and a domestic worker. The care workers worked specific hours on a rota each day. The provider and their partner worked five days a week and one of them was always on site to provide support to people using the service and the care workers. There were enough staff to meet people's needs and there were systems in place to ensure care workers were suitable to work with people using the service. We viewed four employment files for three care workers and the domestic worker. The provider followed safe recruitment practices and files contained a number of checks and records to ensure care workers were suitable to work with people using the service.

The infection control policy provided guidance to staff who had undertaken health and safety training in the last year. Care workers said they, "Use hand gels and gloves" and "Use disinfectants and use gloves [to prevent infection]."

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Care workers told us one of the people using the service could not go out by themselves as it was not safe them to do so and they required supervision in the community at all times. When we asked the provider why the person did not have a DoLS authorisation they told us the person's social worker said they did not need one. However there was no capacity assessment to confirm that the person could make a decision to go out. It was also the responsibility of the provider to make an application to the local authority for DoLS authorisations if they thought that the person might have been deprived of their liberty and it was the decision of the local authority to authorise it. As the person could not leave the home without support and would be restricted if they tried to do so, the provider should have made an application to the local authority as the person could have been deprived of their liberty because they were not free to leave the home. Not carrying out a mental capacity assessment or applying for a DoLS authorisation indicated the provider did not have a clear understanding of the best interests principles of the MCA.

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

Additionally, consent to care forms were signed by both the person and the provider but we noticed on all three where it stated, 'I hereby give / do not give my consent', neither 'give' nor 'not give' had been crossed out to indicate what each person was signing for. We spoke with the provider about this and they said that each person had given consent and they would amend the forms to reflect this.

The training matrix indicated all staff had undertaken Mental Capacity act (2005) training but when we asked staff about the Act, they were not clear on the principles. However they did understand that people should be given choices. We observed staff asking one person what they wanted to watch and changed the channel as requested. Another person said they wanted to go shopping and the provider agreed to take them.

People were involved in planning their care. The people using the service had all lived at the home for more than ten years and we did not see pre admission assessments but each person's file had information that included peoples' backgrounds, family, preferred name, religion and social likes and dislikes.

Staff were provided with appropriate support to develop their skills as care workers. We saw staff supervision notes from January 2018 and appraisals completed within the last year. The provider used an external trainer and on line training. Safeguarding adults training was last completed in November 2016. The provider told us staff would be attending safeguarding, diabetes, insulin, manual handling and MCA training on 17 March 2018. □□

People were supported to eat and drink enough to maintain a balanced diet. We observed people being offered drinks or helping themselves in the kitchen and we saw food was freshly prepared daily. There was evidence of food and menus being discussed in resident and staff meetings. One person said, "Sometimes I choose what I want to eat. The food is good" and "[Care worker] takes us out all the time to buy something for tea."

We saw evidence that people's day-to-day health needs were being met. Care plans provided descriptions of people's various medical needs and how to support them. Care workers knew how to support people's medical needs and one care worker said, "If people are unwell I make an appointment with the doctor." Any medical appointments were recorded in people's files and the provider worked with a number of other medical professionals including the GP, diabetic nurse, mental health team and chiropodist. Records included weight charts and blood pressure charts. A health care professional told us, "[People] have recently been reviewed in the last six months. If patients need to be seen by a doctor they are brought in by carers."

The home's environment met the needs of the people using the service. There was enough space in the home for people to do activities of their choosing. People's bedrooms were clean, bright and comfortable and reflected individual interests. For example one person had an exercise bike in their room and another person showed us religious photos in their room.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with told us care workers treated people with kindness and knew their needs and preferences. Comments from people using the service included, "This is my home for 23 years. It's nice", "[The provider and care worker] are nice. They look after me. They give me medicine and we go out. In the house we play games" and "I like living here because they treat us like a family. We have holidays. It's good food and good caring. They take care of us."

We observed a very relaxed relationship between the provider, care workers and the three people using the service. Staff and people watched television together, chatted and drank tea. People were mostly in the conservatory / dining room and went in and out to the garden and kitchen as they pleased.

Whilst there was no doubt that staff were individually caring, the service was not always caring to people. The provider had not ensured that the care records and risk assessments were updated and reviewed so these were up to date to protect people from any arising risks. Additionally decisions could have been made for people which were not lawful as one person might have been deprived of their liberty without the legal authorisation to do so. This meant that people's rights to make decisions were not respected and their independence was not always promoted.

People were involved in their care and expressed their views. One person said, "Other places you have to do what they say, but not here." Care workers said they encouraged choice and promoted independence. Comments included, "If a client refuses something, for example medicine, we can't force him", "If he says I want this one, I say okay", "I try to encourage independence, like go to the shop and give them money to pay" and "I encourage everything and explain everything like when we go to the gym." A social care professional told us, "[Staff] do encourage [person] to be independent in the community and he has a mobile phone for communication."

People's cultural preferences were supported. We observed the provider asked two people what they would like for lunch in their own language and we saw people watching television in their own language. Additionally, people from a local place of worship visited the home weekly. An information record in the care documents recorded people's food and social likes and dislikes.

Care workers were respectful of people's wishes when supporting them with personal care. They told us, "If I go to a room, I knock on the door" and "I put everything ready in the bath and wait outside for them and then we go into their room and I ask them to choose something to wear."

Advocacy service information was not displayed in a communal area but the provider showed us contact details for a local service. People had contact with their relatives by either visiting them or by phone. One relative said, "If [person] wants to come to me, they [support] him to come over here."

Requires Improvement

Is the service responsive?

Our findings

People's care plans provided some guidance to staff on how they should support people and we saw minutes that indicated the care plans were reviewed at least annually. However care plans were not fully updated to reflect the reviews and when they were, the update was handwritten on the old care plan which made it difficult to see progression. We observed there were no handwritten dates recorded after 2015 indicating the care plans had not been recently updated to reflect people's progress and current situation. In addition, care plans were not written in a format such as easy read, to be more accessible to people using the service for them to feel fully involved in the care planning process.

Each file also contained a 'care approach' record which identified the aim, objective and procedure for each support task. It provided guidelines for care workers about how to provide care that met people's needs. The last typed up copy was completed in 2008 and since then, amendments had been crossed out and handwritten on the 2008 copy which was not accessible to everyone using the service.

Additionally, the provider said they had people's end of life wishes recorded in an old file but they did not show us evidence of where or how this was noted and whether it had been updated.

Furthermore the language used in the care plans was not always person centred. For example one person's care plan said they were 'quite independent but can be very lazy' and 'quite difficult when out'. The also referred to training people to do tasks instead of supporting them and people going to day care instead of day services.

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

Reviews of the care plans were up to date and the minutes indicated people attended their reviews. The reviews noted people's current situation and provided an update since the last review.

Staff maintained daily logs, which recorded what people did and their mood on that day. People also had activity planners and were able to choose not to do the activity on the day. For example we saw on some weeks people went to the gym and on other weeks they chose not to.

Although care records were not always written and reviewed in a person centred way, we saw that people received the care they needed to meet their needs. We saw people were able to get up when they wanted. Staff spoke with people in their own language and they had entertainment in their own language. We saw people being asked what they would like to eat for breakfast and lunch. A care worker told us, "Because they have lived here for a long time, I know what they like; reading, board games. They put a lot of time into each activity. I normally ask them what they want. Different choices on different days."

People we spoke with were happy with the activities they did and told us, "We go out all the time to London in the car", "We go shopping", "I watch TV and at a later time I do cleaning and I go out with [care worker]", "I

do writing or I go out and buy something for the dinner. Now I'm going to the gym." One person who sat with us was writing and said he was practicing his English. Another person was colouring. A relative told us, "They're helping him a lot. Now he's an active and jolly person."

The service had a complaints procedure with an easy read form but had not had any complaints. People had a copy of the complaint procedure in their bedrooms and said they knew how to make a complaint but had not needed to.

Requires Improvement

Is the service well-led?

Our findings

The provider had some systems for assessing the quality of the service and identifying risks. However, checks and audits had not always been operated or recorded effectively. For example, there was no record of care workers having completed competency assessments regarding insulin injections. This meant the audits carried out to review the quality of the care provided were not always effective in identifying areas to improve or identifying potential risks so these could be addressed and minimise.

The systems in place did not identify concerns raised during the inspection and therefore the quality and safety of the service was not monitored effectively or risks adequately minimised to keep people safe from harm. People had risk assessments and care plans but, although reviewed, we did not see any outcomes or updates to the care plans or risk assessments after 2015, to show if the care planned for people was effective in meeting their needs.

In addition, neither staff records nor people's care records were audited which meant areas lacking documents such as up to date risk assessments and DoLS applications were not identified. Whilst people were happy living in the home, the absence of effective quality assurance and governance systems meant that there was no assurance that the quality of the service would be maintained.

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

The provider said they kept informed of current best practice and legislation through information on the internet and talking to healthcare professionals. We discussed attending provider forums with the provider which would have given them the opportunity to network with their peers. However the provider said they no longer attended these forums as they did not find them beneficial. The provider had a good working relationship with local healthcare professionals and one told us, "[Staff] communicate very well with regards to the care offered to our patients"

The provider lived in the home and gave direct care to people using the service which provided them with a good understanding of people's needs and preferences. People using the service also felt they could approach the provider with any concerns. Care workers felt supported by the manager and said, "[The provider] supports me and helps me. She talks to us about improvement and we have meetings. She gives me good instructions", "[The provider] definitely listens when I raise concerns. Every time I see something, I tell [the provider] and she tells all the staff about any hazard" and "The staff are very cooperative. [The provider] is very humble and sympathetic to us."

Feedback was given to staff through supervisions and team meetings, where staff also had the opportunity to provide feedback to the management. One care worker said, "At the team meetings we talk about home improvements, food, residents, outside activities and everything that needs improvement." As it was a small family run service, there was regular and ongoing informal communication and feedback so everyone was kept up to date with any development within the service.

The service last completed a service user satisfaction survey in December 2017. Two regular visitors from the community also completed surveys in February 2018. All people rated the service 'good' to 'excellent'.

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 care and treatment of service users did not appropriately meet their needs and reflect their preferences. Regulation 9(1) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always demonstrate they acted in accordance with the Mental Capacity Act 2005 where a service user did not have the mental capacity to make an informed decision. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of the service users and do all that is practical to mitigate any such risks. The provider did not undertake robust medicines competency testing to ensure staff had the competence and skills to administer all medicines. Regulation 12 (1), 12 (2) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems operated effectively and that such systems enabled the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(1), 17(2) (b)