Havencare (Wirral) Limited

Haven Care Wirral Limited

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was announced and site visits to the office and to people's homes, were carried out on the 6 and 7 December 2017. We made telephone calls to some of the people who used Haven Care support services and to some of the staff who supported following these visits.

At our last inspection in October and November 2016, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to the use of systems and processes to assess, monitor and improve the quality and safety of care. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve the key question, 'is the service well-led', to at least good. At this inspection we found that the issues we had identified had been addressed and rectified.

However, at this inspection, we found that some statutory notifications had not been made to us in relation to some safeguarding concerns, which is a ratings limiter to the 'well-led' question. These concerns had though, been notified to the local authority.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community and supports people with a range of needs. The people whom it supports range from older to younger adults all of whom live in their own homes in either an individual domestic setting or in supported or extra care housing. Haven Care employs approximately 144 staff and supports approximately 130 people in these various settings in the community. These figures vary according to the needs of people needing support.

Supported housing provides care and support to people living in a 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support services.

Recently, some other providers had reduced or ceased trading and some of the people they were supporting were transferred to Haven Care. These were the people who lived in the supported living and extra care accommodation. Some of the usual staff who supported them had also transferred to Haven Care, which enabled continuity. The process is colloquially known as TUPE (or Transfer of Undertakings Protection of Employment). The new services which Haven Care provided were to a group supported living community and a service in an extra care housing service. The service to their original service users who lived in their own homes in an individual domestic setting in the community continued to be delivered.

The service requires a registered manager and there were two in post who had been there for several years. 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. One of the registered manager's for Haven Care is also the provider of the service. The other registered manager was not available for the inspection.

At our previous inspection we found that audit and quality assurance systems were not robust. At this inspection we saw that improvements had been made in relation to these. The provider's managers had completed spot checks on staff and care record and medication record audits. We found that the auditing and quality assurance processes had improved. The provider was also a registered manager of the service and there was another registered manager who was on long term leave at the time of our inspection. The provider and the other managers of the service (the deputy managers and the care coordinators of the teams) who we talked with, had an open, supportive, accountable and transparent relationship with people who used the service, and the staff. They also had a similar relationship and had had good partnership working, with various organisations.

Recruitment processes were robust which ensured the safe employment of suitable staff. There were sufficient staff to meet people's needs but recruitment was continual, although the service had a good staff retention record.

Staff were being bought up to date with training although all had had either their previous employers training or that provided by Haven Care; supervisions had been increased and appraisals completed and planned. A schedule of training and supervision dates had been completed for the following year.

People were protected from the risk of abuse. All staff had completed training in safeguarding vulnerable adults, but some needed to be updated. They all knew how and to whom to report any concerns they may have This helped to ensure people's safety.

People told us that positive relationships had been developed between them and staff. They told us staff were, "Lovely" and "Helpful". One family member had written in a satisfaction survey, that staff made their relative laugh and other people told us they felt relaxed and at ease whilst being supported by staff.

People told us and we saw, that they were treated with dignity and respect. People told us that staff conducted themselves respectfully and left their homes clean and tidy.

People's care records contained accurate and up-to-date information about their needs. People were involved in their care planning and their preferences and choices respected. Risk assessments were in place and provided information to staff around how to manage those risks presented to people. This helped ensure that staff had access to information about supporting people and how to keep them safe.

There were sufficient numbers of staff in post. People commented that staff usually arrived on time, or within an acceptable time frame. People confirmed that staff always turned up for their care call. Staff told us they had enough time to spend with people in order to support them and chat with them and did not feel stretched. They told us that travelling time was built in to their schedules and was separate from the call times.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. This ensured that people's rights were protected under the Mental Capacity Act 2005. At the time of this inspection there were no people subject to any restrictions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Recruitment was carried out in a safe way. There were sufficient numbers of staff in post to meet people's needs. Staff were able to tell us about safeguarding and knew how to report any concerns they may have.	**Good**
Is the service effective? The service was effective. Staff had received the training they needed to carry out their role effectively although some staff who were transferred from a previous service, needed some updating. Staff supervisions were completed and a schedule of supervision and training was in place for the following year.	**Good**
Is the service caring? The service was caring. Positive relationships had been developed between staff and people using the service. People commented that staff were respectful and worked to promote their dignity. Processes were in place to ensure people's confidentiality was protected.	**Good**
Is the service responsive? The service was responsive. Care records clearly outlined people's needs and contained accurate and up-to-date information.	**Good**

People had been involved in their care planning decisions and had been able to express preferences and make choices.

People were encouraged and enabled to pursue any social activities they preferred.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Statutory notifications had not been sent to CQC This is a ratings limiter for this question.

However, appropriate referrals had been made to Wirral social services and other bodies, as necessary.

Quality assurance processed and records had improved and people, their relatives and staff mostly had a very good opinion of the service.

The provider and the other managers of the service were approachable, helpful, open and transparent and had a shared vision of where the service was to be developed.

Haven Care Wirral Limited

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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place because the service had been inspected in October 2016 and was rated as 'Requires Improvement'. This inspection was to check that the issues identified in the 2016 inspection had been addressed. The inspection team consisted of an adult social care inspector and an 'Expert by Experience'. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service,

The first day of this inspection took place on 06 and 07 December 2017 and was unannounced we rang relatives after the inspection. We made telephone calls to some of the people who used Haven Care support services and to some of the staff who supported following these visits. These calls had been agreed with the recipients, previously. We also visited several people who lived in the supported living service and the extra care service where Haven Care provided staff to support individuals within those settings.

Prior to the inspection, we checked with the local authority and also looked at our own records to see if there was any information we should consider during this inspection. We looked at the information the service had sent to us as 'statutory notifications'. We had requested that the service submit a 'Provider Information Return' (PIR) which had been completed and sent to us in August 2017. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the local Healthwatch website to see if they had recorded any concerns about the home.

During the inspection we visited and spoke with seven people who used the service in their own homes in all settings, with six people and eight relatives by telephone and with eight staff members face to face, including support staff, care coordinators, the registered manager/provider and the deputy manager. We also contacted and spoke with a further nine support staff by telephone. We looked at six people's care records either as paper files or electronic files. We looked at the training and recruitment files for two recently recruited staff and two longer serving staff. We also checked records relating to the day-to-day running of the service, for example audit records and staff supervision files.

Our findings

People we spoke with told us they were happy with their care and felt safe. A person at the extra care home told us, "It was the best decision we ever made to move here. We feel safe. We get care when we need it". A person at the supported living accommodation said, "I am out a lot, but when I am here, I feel safe. Nobody can get in".

A staff member said, "The most important thing about safeguarding is that you listen. It is important to hear what the service user is telling you. If you think it is serious, report it to the office. I would know from the service user's tone and how they look that there might be a serious concern".

We saw from the records that staff were recruited safely and the files held information on staff's recruitment, the references and the criminal records checks which had been obtained prior to them working at Haven Care. For example, we saw completed application forms and recruitment records which included two references, one from the applicant's last employer. We found that Disclosure and Barring Service (DBS) checks had been carried out for new staff before they started work. We saw that applicants had provided a photographic form of identification, such as a passport or driving licence. In addition they had brought in birth certificates or visas to prove their right to work in UK and proof of address, which were recorded in their recruitment files.

New staff received an induction which covered an explanation of their role, the line management and structure of the service, disciplinary, grievance and other policies which were also available in the employee hand book and they undertook the provider's mandatory training. They received the Care Quality Commission (CQC) code of practice and were issued with the service uniform and identification badge to enable people to feel assured that the worker was who they said they were.

The service employed 144 staff to provide support for 130 people who used Haven Care. The provider told us they were able to cover any staff absences with their own staff and now had a small core of bank staff; they rarely used any agency staff. This was confirmed by people who also told us that staff were almost always on time and that they stayed for the required time. There was always a care co-ordinator on call over each 24 hours to support staff who worked 'out-of- hours' and through the night. One person told us, "I see carers now more than I did with the previous provider".

Many staff told us they had had safeguarding training; some thought it had been in the last year, others were not sure. A staff member who had been transferred over from a previous employer [TUPE or Transfer of

Undertakings (Protection of Employment)], told us they had not had safeguarding training since joining Haven Care. They told us they had had safeguarding training with their previous employer. However, we saw in the training matrix that all personnel were scheduled to have refresher training in safeguarding, in the forthcoming year.

All the staff we spoke with were aware of the policies and procedures regarding safeguarding and one told us, "If I had any concerns, I would speak to the line manager. That is usually the coordinator or otherwise the care manager. Everything is documented, we write it down. I am confident that I am listened to and that concerns are acted on." Staff told us there had been several safeguarding incidents, but these had been dealt with by managers and the appropriate referrals made to the local authority safeguarding team. An example of a safeguarding concern was that there had been an inappropriate use of social media.

Staff we spoke to told us about other examples when they had raised safeguarding concerns. One said, "I told coordinators about what I suspected was going on. I then had to give them regular updates [on what had been noticed]. This was then dealt with". Staff told us they felt people were safe in the main, but when things did go wrong or there were concerns, coordinators and managers handled this quickly. One staff member told us, "I am confident things would get dealt with, but if I ever needed to I would feel able to raise concerns elsewhere and 'whistle-blow'". Staff told us they would 'whistle-blow' to the local authority, the CQC or the police".
We saw that records were completed appropriately and stored in a safe way to ensure confidentiality. Most were computer based but required a password to access them.

We looked at risk assessments in people's care plans. These included personalised plans and basic 'environmental risk assessments'. These described for example, hazards posed by wet floors or electric heaters. We saw staff had assessed these on 24 November 2017 and that they were due for review in November 2018. The registered manager told us that risk assessments were reviewed earlier than planned if there was need to. We saw that initial assessments led to 'keeping safe' plans that were based on known risks for the person. There were clear links between the risks in the support plan and the client support plan. This identified in the main how the likelihood of risks would be reduced.

We asked staff how they knew about possible risks to people using services. One told us, "When you go in, you read the care file first. In the care file it tells you about any hazards or dangers; it protects you, is kept up to date or redone if needed". Another staff member told us how they were working with people to keep them safe while giving them more independence. They gave an example and said, "[Name] used to have to come to the shower room up here, but it was not really good for them. [Name] now has a shower in their own flat, but we work with them to ensure we always clear away any trip hazards".
Staff told us that for example where they needed to use equipment, two staff attended the call to do this safely. One told us, "We use 'double up' calls if we have to use equipment, such as hoists. You use it safely and follow your training". Of the 14 people and relatives we spoke with by phone, five relatives told us that they required two carers to help them mobilise the person needing the service and all told us that two carers always came. Comments were made such as, "There are always 2 people for hoisting" and "They always send 2 carers together".

Some people were able to administer their own medicines, but where people required support to administer their medicines; this was provided by staff who had received medication administration training. The current medication administration records (MAR's) were stored in the person's home and were correctly filled in for these administrations. Medicines were stored appropriately in people's homes and audits of the records and stocks showed that medicines had been administered according to prescription and that the stock of medicines in people's homes, tallied with the MAR's. One person told us, "There is a meds call here twice a day. They take the meds out of the safe and then write in the book. If it was left out I'd probably lose it". Older MAR sheets were brought back to the office, audited again and stored safely.

Staff were seen to use appropriate personal protection equipment and we saw several staff wash their hands or use alcohol gel as necessary. One person told us, "They wear gloves and aprons and wash hands. Very good". Other people confirmed this and said similar things. We asked staff how good infection control was maintained where they provided care. Staff told us, "We use aprons and gloves, personal protective equipment. All the staff do it. We have a set staff team here and everybody knows what to do" and "Aprons and gloves are always available; you can pick them up from the office if you need to". Staff also told us they kept such equipment in their cars. Staff in the 'extra care' setting told us they used 'special' bins to dispose of gloves and aprons. Staff told us they had received training in infection control. Senior staff checked staff's infection control practice when they carried out 'spot checks' during work-based observations.

The provider told us how the service was aware of risks to people due to their diverse needs. Nearly one third of the staff had received equality, diversity and human rights training at the time of submitting the provider information return (August 2017) and we saw that most were scheduled to complete this training in the next year.
The provider explained how the service was working to keep one person in particular safe, as they might be at risk of discrimination in the community. They told us how important it would be for the service to work closely with this individual. This would help the person to become more independent while keeping them safe. One staff member told us told us they had, "Heard of equality and diversity; it means making sure people have equal rights and are not victimized" .Another staff member said, "One of the people I work with uses a wheelchair. But that doesn't mean they don't go to the pub in the evenings and they make their own decisions around this, and we know people make sure he is ok at the pub".

At the time of the inspection no accidents or incidents had occurred. We spoke with the provider who confirmed that a record of these would be kept where they did occur.

Good

Our findings

One person told us, "Oh yes, they know what they are doing".

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 was in their best interests and legally authorised under the MCA. In community based settings authorisation to restrict a person's liberty needs to be granted by the Court of Protection. At the time of the inspection there was no one who required their liberty restricting in this way.

Most staff could tell us about the MCA and staff appeared confident in this area. However, other staff were not always clear about the MCA and had not training with Haven Care recently if they had transferred via TUPE. However, the staff members in this case told us they had had MCA and DoLS training with their previous employer. We saw in the training matrix that all staff were scheduled to have refresher training in MCA and DoLS, in the forthcoming year. This was confirmed to us by the training provider for the service. The service had also passed on to staff a National Health Service mobile app. This gave them useful key information about the MCA and other topics.

In people's care plans we saw evidence of consent forms. The first part of these recorded the person's consent to care and support, to consent to their care and support plan and consent to information sharing. Within the second part of the forms we saw there was room to record a capacity assessment and a link to the provider's policy and the legislation.

There was an induction programme which included shadowing other staff and completing training specific to their roles. One person said, "Sometimes they come with a third person; a trainee and they read the care package". They went on to tell us, "They make sure they train new staff".

We looked at the records of staff training which confirmed that all staff received or had planned, a range of training relevant to their roles and responsibilities. The provider now used 'Skills for Care' which is a government supported agency, to provide their induction training. This induction course is called the 'Care Certificate'. The staff we spoke with had completed the provider's mandatory training for specific subjects.

We saw that staff had attended a range of training including malnutrition, first aid, end of life care and positive behaviour support. Some staff had received specialist training to help them administer medication and feed through a PEG (percutaneous endoscopic gastrostomy) tube. This is a way of administering nutrition through an aperture directly into a person's stomach, when they are not able to take nutrition orally.

There was additional training booked surrounding moving and handling. Most staff had also achieved Health and Social Care Diplomas Level 2 and some had achieved Level 3. One staff member was working their way to a high level management qualification and others had leadership and management qualifications already. The provider had addressed the issues found at the previous inspection and had developed a tool for monitoring and arranging training.

Staff told us that they were happy with the training provided and there was a lot of it. The provider also employed a specialist law firm which provided regular training programmes to back up the policies and procedures in place. This was confirmed by the firm. We also noted that the service had strong links with a nearby college and were working towards apprenticeships and other learning opportunities.

Supervisions were now completed with staff on a routine basis and recorded on the electronic data base the service used. Supervision provides staff with the opportunity to discuss any training and development needs they may have. It also enabled management to raise any performance related issues with staff. We were provided with a supervision and appraisal schedule which showed that staff would receive supervision on a quarterly basis and an appraisal annually. Staff told us that supervision could be on the job or at the provider's office. Spot checks, or work-based observations, were completed randomly. This involved coordinators watching staff as they worked to see how they were doing. A staff member said, "The coordinator comes and observes you to check that you are doing what you have learned. For example watching you when giving medicines". A schedule of annual appraisals had been instigated, which meant that an overall understanding of an employee's performance would be completed with any problem areas identified and addressed.

Some people we spoke with did not receive support from staff with meal preparation; others did. Staff and the people they supported told us they were aware of people's dietary needs and monitored them. Records showed that staff had completed training in food hygiene. This helped ensure that staff had the skills needed to prepare food in a hygienic and safe manner. We asked staff how they ensured people eat and drink enough. Staff gave us an example, "For the person I look after, a nurse comes once a week. They work with the nutritionist to see if the person is eating and well or not eating enough. It is all logged. We always speak to the person's main carer and if they are not eating enough, they speak to the nutritionist".

Where required, support had been provided to people to access input from health care professionals, for example their GP or the district nurse. This helped ensure people's health and wellbeing was maintained.

Good

Our findings

We spoke with people who used the service and all told us they were happy with the support and care they received. One person told us, "I am very happy with all the support I get" and another said, "The care is much improved [from the previous provider]; it is excellent".

We observed interactions between people and staff, which demonstrated that there was a good deal of understanding care and respect by staff towards the people they supported. One person told us, "Very good. Some of the carers are excellent. All acceptable ... very cheerful and we have a lot of banter".

When we asked one person if they were treated with dignity and respect, they said, "Yes, staff are kind and caring and treat us as individuals and respect us and encourage our dignity". They also told us that staff protected their dignity during personal care tasks, and that they felt comfortable in their presence. Staff were able to provide appropriate examples regarding how they would maintain people's dignity, for example by ensuring that curtains and doors were closed to ensure privacy.

People commented that staff left their homes clean and tidy after they had carried out care tasks. "They treat my home as if it were their own", one person said to us.

Staff we spoke to told us, "People have the right to be looked after well, to be supported but to have independence at the same time" and "Treat [people] how you want to be treated. We are guests in people's house and we need to remember that".

A person told us, "We have our morning routine; it sets us up for the day. I get everything ready before the staff come to provide the call for [the person's spouse]. This usually works really well. This morning was the first time since we moved in that staff came much earlier. I am not sure why, but I do appreciate that they need to fit everyone in".

Staff told us, "We listen to people. If someone says 'I do not want that carer coming back', then things get changed and they get someone else". People told us that things were explained to them. One said, "They always explain what they are doing".

Staff told us they had completed a training course entitled 'dignity in care'. One staff member told us, "It was really interesting looking at it in depth from the person's point of view".

We asked staff how they promoted people's dignity and respect. "It is different in domiciliary care to supported living. In domiciliary care, we support people to do as much for themselves as possible. If the person needs personal care especially we ensure they are covered up as much as possible [to preserve dignity]. In supported living, people do not really need help with personal care. There we might just need to prompt the person for example to have a shower".

We asked staff if they had had received training in equality and diversity. Carers told us they previously had, but were not sure about having had it with Haven Care. "It is about treating everyone with respect". The provider told us there was an exercise that staff completed around equality and diversity, a set of questions. We saw copies of this exercise where staff had to complete sentences or choose the right answer from a selection.

Positive relationships had been developed between people and staff. The provider worked to ensure that people were supported by consistent members of staff. There was a positive atmosphere amongst the staff team. We observed staff chatting to one another in a kind and supportive manner, and they told us that they felt morale was high within the team.

At the time of the inspection there was no one who required the use of the local advocacy service. However, the provider demonstrated a good understanding of how and when to access the support of an advocate. An advocate acts as an independent source of support where people need to make decisions about their care needs. This helps ensure that people's wishes and feelings are taken into consideration.

People's confidentiality was protected. Personal information that was stored in the office was stored securely in locked cabinets. Computers which held confidential information were password protected and 'backed up' to ensure that only authorised individuals could access these.

A person commented to us that, "The service provides a great quality of care; care is excellent with me".

Good

Our findings

One person told us, "They asked me about what I wanted in the care plan. It's definitely a lot better than the last service. The care is a lot better". A relative said that a staff member had, "Established a relationship which is very nice and I wouldn't like to see it changed in any way".

One staff member told us, "We encourage people to make choices and they can be right or not right. We explain choices to them. If it was a big choice or 'not a right choice', we would explain the consequences. If it was something serious, we would tell the office".

A manager carried out an initial assessment with a person prior to them starting with the service. They looked at their individual and current needs and ensured that these could be met by the service. Information from other professionals to helped inform decisions around whether they could meet people's needs. The care plan was then devised with the person and any family and friends if available, to ensure that the right support was available to promote their independence and well-being and to enable the person to live in their own home. A paper version was kept at the person's home and an electronic version was held on the computers in the office. Daily records were completed and left in the person's home, to record the support and interventions provided, for the next staff member. This helped ensure that staff knew how to meet people's needs.

People told us that they had the opportunity to express their views and be involved in the care that was being provided. One person told us that their wish to be supported only by female members of staff had been respected. People told us that staff provided the care and support that was appropriate to meet their needs. Another person told us staff respectfully encouraged them to do things for themselves, which promoted their independence. We spoke with staff who demonstrated a good knowledge of the people they supported. We asked staff what the service did well to meet people's needs. A staff member told us, "We encourage people to be independent but they have extra help where they need it".

People's care records contained details about their likes and dislikes, such as their food preferences. We saw that a person was described as 'fussy eater' under their dislikes. To promote a positive, strength-based approach that gives the person confidence, it may be useful to review such statements, as there could be a clearer description of what the person in fact does like to eat.

Other care records contained details of their family members and other important people in their lives. This helped staff get to know people, and supported the development of positive relationships.

Information within people's care records was reviewed on a routine basis to ensure it stayed up-to-date and accurate. This helped ensure that staff had access to relevant information regarding people's needs.

When we spoke to people we asked whether they knew where their care plans were. Their care plans were in their own homes and they were happy to show them to us. One person told us, "Here, we are supported with extra care, while living independently. We were even allowed to bring our cat with us".

In people's care files we saw a form that noted the person's consent to the care and support plan, as well as information sharing. We saw that personal care files were reviewed regularly.

A staff member explained to us about the time they spent with each person. "I do what I need to do, take the time that people need. Prompting people to take their medicines takes about 15 minutes and personal care can take 30 or 45 minutes. But some days people need more attention, if they are not well". The staff member told us that they could be flexible in order to accommodate people's needs. One person told us, "They are very good and do what I want them to do. Everything is fine".

One of the support workers had learned some sign language so they could communicate with a person they were supporting. The staff member also arranged a pantomime which included signing, so the person could join in to some of the songs. The person's relative said, "[Staff member] goes over and above what they are supposed to do. They run a social club and has taken on board the signing so they can support [Name]"

People were encouraged or enabled to take part in various activities or holidays as out lined in their care plan. Staff would accompany people on these if it was necessary. For example, one person was regularly taken to electronic supermarkets as they were important to them and another enjoyed shopping.

In the extra care setting, there was a restaurant and hairdressers which people were able to use if they chose and some enjoyed the social side of living in this setting. Staff had time to talk with the person they were supporting. One said in a satisfaction survey, 'Yes, I always enjoy our chats during the visits'. A relative had written, [Name] likes every one of them and is always joking and singing with them'.

No one supported by the service was receiving end of life care at the time of this inspection. Some staff we spoke to told us they had supported people at the end of their life. One member of staff described compassionately how they had worked closely with the person and family during this time to respect everyone's wishes. Staff told us they had previously had end of life care training but that it had been some time ago. A staff member told us, "If I was worried, I would call the coordinators".
A complaints process was in place which had been made available to people using the service. The service had only received one formal complaint over the past 12 months. The provider had responded in a timely manner to the concerns by investigating and taking appropriate action to address the issues. Other people we spoke with told us that they did not have any complaints, but would raise concerns if they felt they needed to. We heard that on the morning of our second visit staff had come earlier than the person expected, but this had been the first time. We asked if the person felt they could speak to someone about this. "I am sure we could and I am sure they would listen. But we understand they need to organise everything. We do not really want to cause trouble". We discussed this with the provider who told us they would encourage any person who wanted to, to make a complaint without fear of any consequences. A relative told us, "I have no complaints at all".

Requires Improvement

Our findings

In a recent satisfaction survey, a person had written, 'Well looked after; could not fault your company'.

The provider told us, "Staff want to make a difference. We all want continual and continuous improvement.

At our last inspection in October 2016, we found that there were ineffective systems in place to assess, monitor and improve the quality of care and we found that the records relating to the management of staff needed to be accurately completed.

At this inspection, we found that these areas had been addressed. Systems and records had been improved and that the provider had developed new quality audit tools which were used appropriately. The manager in charge of training and quality assurance (QA) showed these to us on our visit. We saw that 'who' would be responsible for the action and 'by when' would be recorded going forward to support timely, effective follow up. One of the managers was completing a higher level managerial qualification and they were incorporating this QA and the need for it, into their dissertation about continually improving the quality processes of the service.

We saw that care records had been reviewed and audited, that out of date, completed MAR sheets had been brought into the office and checked. There was now supervision and training matrix and plan and staff told us that both these activities had been regular and effective.

The registered provider had a number of other quality monitoring checks in place to monitor the service; for example spot checks and competency checks on staff and care plan audits. These helped to ensure that staff were working to a good standard, and that information within care records was accurate.

However, statutory notifications had not been sent to CQC although appropriate referrals had been made to Wirral social services and other bodies, as necessary. This omission limits the rating available to the 'well-led' question and subsequently the rating for it is 'requires improvement'. The provider has since submitted the required statutory notifications to CQC retrospectively and they told us this would not occur again.

Supervisions had been increased to four per year and if any were late, they were done as soon as possible afterwards. The provider now used a mainly electronic system for recording the activities of the service, which was part way through having some historical data input on to it. We saw both paper and electronic information. Policies had been reviewed and updated appropriately.

Staff told us that the provider and the other managers in the service were supportive and understanding of any personal or emotional needs they had. This helped to promote a positive and inclusive culture within the organisation. This had resulted in there being good staff retention within the service which helped promote good continuity of care for people using the service.

A recent integration of staff from other services had been completed. Some staff had found that the transfer process had not been clear enough. However in the main we heard staff echo this comment from one staff member who said, "It was quite confusing with [the former provider] first. But Haven Care had a meeting with us that explained it all and that really helped". Most of the newly transferred staff who we talked with told us the Haven Care managers had been caring and understanding about the feelings of the staff and any insecurity they might experience, as they went through this process.

We heard a lot of positive comments from staff about the culture of the service, such as, "I love the job. The managers are very caring, they do things" and "The difference is that [at Haven Care] I feel that I am being asked [to cover] and am not just 'told to'. We have a good team and try to cover shifts, but 'worst case scenario' someone out of the office comes and does it".

Most of the staff we spoke to said, "I feel well supported. Everything gets done and there is strong leadership." "Everyone I have worked with was wonderful. Managers are very approachable and I can speak to them".

We found the provider and the other staff in the office, as well as the support staff in people's homes, were pleasant, helpful open and transparent and the provider had discussed their vision for the service and how they planned to achieve it. They obviously valued their staff and appeared to have a very good relationship with them. We asked the provider if staff knew what the vision for the service was. The provider responded, "They want to do their best for people who need any type of care".
Team meetings were held with staff and minutes of these meetings were recorded. This provided managers with an opportunity to update staff on any important information.

People using the service had been provided with information about policies and the support the service provided and what they should expect. There were relevant names and contact numbers for people or their relatives to call if necessary. In the staff handbook, there were policies for example, about the use of personal mobile phones and social media.

A half yearly survey had been sent out to people and their family members in October 2017 to ascertain their views of the service. A relative told us, "They send a form to fill in regarding satisfaction about every six months". Another said that they, "Fill in a questionnaire every couple of months".

The questionnaires all showed that people and their family had commented mainly positively on the service and no one had raised any major areas of dissatisfaction. For example, one person had written, about time keeping, 'Yes it's good most of the time' and another had written, 'It's alright for me but one of the two carers can be around 20-30 minutes late'.

The provider had good community links with colleges and other organisations and worked in partnership with them. They said that they wanted to promote social care and encourage young people to enter the profession. The provider also told us they were part of a registered managers' network in Wirral and Liverpool and had links with other business groups in the area.

In the supported living flats, the communal laundry had broken down which meant that people had not been able to wash or dry their clothes. Although this premises issue was not part of Haven Care's responsibility, we heard the provider have several involved conversations on behalf of the tenants, with the housing association responsible for the required repairs.