HF Trust Limited

HF Trust - Kent DCA

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
HF Trust Kent DCA is a supported living service registered to provide personal care. The service provides support to people with a learning disability and/or autism living in supported living settings, so that they can live in their own home as independently as possible. At the time of the inspection they were providing support to 69 people who were in receipt of the regulated activity personal care. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People lived in their own flats and had access to their own facilities such as bathrooms and kitchen. There were a number of different locations across Kent where the service was providing support to people, known as clusters. Each cluster had their own manager, overseen by the registered manager.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Risks to people were not always assessed or managed. For example, risks to people with epilepsy, people at risk of falling, risks relating to constipation and choking had not always been assessed and mitigated. Medicines were not always managed safely. There was not enough appropriately skilled staff to meet people's needs and keep them safe.

Right Care:
Staff told us they understood how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse however not all incidents were documented to ensure concerns could be raised. People's care, treatment and support plans didn't always reflect people's range of needs or promote their wellbeing and enjoyment of life. People were supported to maintain balanced diet.

Right Culture:
There was a lack of effective oversight of the service. We found inconsistencies within the clusters, where lessons were not learned and shared throughout all the service. There was not a positive culture within all the clusters to ensure people lived empowered lives. Some communication we reviewed about people was not respectful. Staff did not always support people within all clusters to achieve their aspirations and goals. People and their relatives were not always involved in care planning.

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 01 May 2018)

Why we inspected
We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safeguarding and allegations of abuse. A decision was made for us to inspect and examine those risks.

We undertook an inspection to review the key questions of safe, effective, and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe, effective 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.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to risks to people, the failure to ensure the principles of the Mental Capacity Act were consistently followed and the oversight and governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

HF Trust - Kent DCA

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
This service provides care and support to people living in 12 'supported living' settings, so that they can live 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

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

with a healthcare professional. We used this information to plan our inspection.

During the inspection
We visited 4 settings and spoke with 10 people and 5 relatives about their experience of care their loved one received. We spoke with 17 members of staff including the registered manager, cluster managers, support staff and agency staff. We reviewed a range of records including 13 care plans, daily notes and multiple medication records. We reviewed a variety of records relating to the management of the service including staff recruitment files, training and supervision.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

- Risks to people's health were not always assessed and well managed across all of the clusters. People's risk assessments did not always contain enough guidance for staff to support people mitigate the risk within all the clusters.
- People who lived with epilepsy were not always supported by staff to manage this effectively. On one occasion someone was documented as having a 15 minute seizure. Staff did not alert management of the seizure and did not administer the person's rescue medicine in line with their risk assessment.
- Some people who were at risk constipation did not have risk assessments or support plans in place. People who were prescribed medicines to support them with their constipation did not have monitoring charts in place to identify if it was being well managed, and there was not always guidance in place informing staff when to seek support from the GP. One person had been hospitalised due to their constipation.
- Choking risks had not always been well managed or mitigated. For example, a person was waiting for a speech and language therapy (SALT) assessment due to them having difficulties swallowing. Staff told us that they were giving the person pureed food, however during inspection the staff member gave the person a hard chocolate sweet. The person did not have guidance in place for staff to follow to reduce their risk of choking, or actions to take should the person choke.
- Staff had not followed emergency evacuation protocols. People living in the service had a personal emergency evacuation protocol (PEEP)(). During an emergency fire alarm, staff failed to follow a person's protocol which detailed they needed to use an EVAC chair. An EVAC chair is a device manufactured for the smooth descent of stairways in the event of an emergency. This person subsequently fell on the stairs during the fire evacuation.

The provider failed to ensure people's health needs were well managed and mitigated. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- There were not effective system in place learning lessons from incidents and accidents.
- Staff did not always document and report incidents to ensure action could be taken. For example, within one cluster, choking incidents had not been reported. A person was documented within the communication book as having choked, however there was no incident form, or updated guidance for staff to follow.
- When people had seizures this was not always consistently documented. Staff had documented in a person's daily notes that they had a seizure. There was no incident form, and this was not documented within the persons seizure chart. The cluster manager informed us they were aware the person had experienced more seizures then were documented on the seizure chart.

The provider failed to ensure incidents and accidents were robustly assessed. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed safely. People were supported by staff who did not consistently follow systems and processes to administer, record medicines safely.

● Staff did not always support people with their medicines in the correct and prescribed way. For example, a person who had epilepsy was not given their emergency medicine in line with their protocol. The seizure had not been recorded in the person seizure records and a senior staff member or manager had not been informed of this prolonged seizure. There was no medicine administration record (MAR) for staff to complete.

● Some people were prescribed medicines on an 'as and when' basis, for example pain relief. When this was administered, staff did not always document if the medicine had the desired effect. Records showed that one PRN medicine was given twice a day, every day for 25 days without any reasons for the medicine being administered.

● Medicines were not always stored safely. Some liquid medicines and creams did not have an open date on the bottles to ensure the medicines were discarded after a certain time period, in line with manufacturer guidelines. Using medicines that are out of date can reduce the effectiveness of the medicine.

● Guidance for people's rescue medicine was not up to date. For example, a person had their emergency epilepsy medicine changed in October 2022, however the guidance within their medicine folder referred to this medicine.

The provider failed to manage medicines safely. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always enough suitably skilled and competent staff on duty to support people and keep them safe.

● The number and skills of staff did not consistently match the needs of people using the service. Staff who worked at one of the clusters had not been trained to administer emergency epilepsy medicine where there was an identified need. We reviewed the rota for that cluster for the week, and there was no staff who could administer emergency epilepsy medicine. We discussed this with the cluster managers and registered manager and they took action to train staff to ensure there was always a staff member on duty who could administer emergency epilepsy medicine.

● Some of the clusters were supported by a high volume of agency staff. Where possible these staff had worked with people previously, and in some cases knew people and their needs very well. A relative told us, "The only problem there is there are changes of staff and he can get really anxious."

● There were systems and processes in place to ensure staff were recruited safely. Before new staff started working with people, Disclosure and Barring Service (DBS) checks were completed. These provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● The provider had not always ensured that people were protected from the risk of abuse.

● Although staff told us they understood their responsibilities to safeguard people from the risk of abuse, we identified that not all incidents had been identified and reported to the local authority safeguarding team.

● When concerns were raised with the local authority safeguarding team the cluster managers and registered manager worked with healthcare professionals to address concerns.

● Most staff had up to date training in safeguarding people.

Preventing and controlling infection
● People were protected from the risk and spread of infection.
● People were supported to access vaccinations to help reduce the risk and spread of infection, for example flu and COVID19 vaccines.
● The provider ensured there was enough personal protective equipment (PPE) available for people and staff.
● People had been supported to keep their homes clean.

Requires Improvement

Is the service effective?

Our findings

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

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
- Staff did not always work within the principles of the MCA, and did not always ensure that capacity assessments, and best interest meetings were completed when people lacked capacity to make decisions.
- People with sensors or monitors in their bedrooms did not have capacity assessments or best interest decisions. For example, a person had an audio monitor in their room to alert staff if they were unwell. The person did not have capacity to consent and best interest decisions or capacity assessments had not taken place to see if this was the least restrictive option. This restriction had not been reviewed by cluster managers or the registered manager.

The provider failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff did not always have the skills and experience to support people. For example, an agency staff member we spoke with was unaware of rescue medicines people within their cluster needed.
- Staff, including agency staff, told us they had the opportunity to review people's care plans and risk assessments prior to supporting them. However, staff did not always follow the guidance in place, for example during evacuations, or when people had seizures and when people fell.
- Staff had received training in a variety of areas including supporting people with a learning disability and

autistic people, supporting people to transfer safely and infection control. However, some staff we spoke with felt they needed increased training around de-escalation, communicating with people who did not use speech, and supporting people who could become very distressed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People did not always receive timely consistent support.

● Staff told us one person was at risk of choking. Staff had made an urgent referral to the SALT team in December 2022, however, at the time of our inspection they had not been seen.

● People were not always supported by staff to access other health care services. For example, a person could become distressed if they needed to attend health appointments. For these instances their care plan stated that the person was to take medication to relieve their anxieties. The person did not have any of the medication in stock or on their MAR. The person had refused to engage with the GP when concerns were raised, however staff had not re-visited if they needed the medication to enable them to be treated.

● Within other clusters there was evidence that support from healthcare professionals had been sought. People had been referred to the occupational therapist, mental health team and falls team. Some clusters had regular visits from the GP.

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

● Support plans for people did not always contain up to date care and support assessments including medical, psychological, functional, communication and preference and skill. Care plans and risk assessments had not always been updated following incidents to ensure they contained the most up to date information.

● The quality of care and support plans varied from cluster to cluster. Some cluster managers had a good understanding of the needs of the people they supported, and this was reflected in their care planning and assessment. For example, one cluster had detailed positive behaviour support plans with de-escalation plans and considered the least restrictive options for people. Another cluster had detailed epilepsy care plans, however this was inconsistent across all the clusters.

● Not all support plans promoted strategies to enhance independence and demonstrated evidence of planning and consideration of people's long term goals.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to maintain a balanced diet. In some clusters people ate together, creating a social event for people to be engaged with one another.

● Within some clusters people were involved in meal planning and preparation. Within some people's flats they had lowered counters for wheelchair users.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Systems in place to improve the quality of care throughout the service were not effective. We identified significant concerns during our inspection and asked the registered manager to take action to keep people safe. For example, ensuring there was always a staff member on shift within clusters where people needed emergency epilepsy medicines.
- There had been limited oversight of the clusters due to staff absences. Audits and spot checks that should have been completed by the registered manager and the management team had not been. Issues highlighted within this inspection had not been identified by any of the management team. For example, a person's medication records had been audited, however issues identified during our inspection including contradicting guidance and MARs not being in place had not been highlighted and acted on.
- Care plans we reviewed did not provide the level of guidance staff needed. A staff member told us, "The care plans need reviewing, people's needs have changed since they were put in. They are not great, not easy to follow." We found care plans needed improvement around medicines management, epilepsy, constipation risks, falls risks and choking risks.
- The provider was in the process of moving to a bespoke online care planning system. Sometimes not all staff could access this, so some information was collated on paper. However, cluster managers told us this could not be uploaded retrospectively for that day. The oversight of daily records, and incident documentation was not in a format which was easy to review and act on for cluster managers. The registered manager was aware of these issues and told us they hoped this issue would be resolved when they have fully moved to the online system.
- There was a system in place for reviewing accidents and incidents, however this in some clusters was ineffective as staff failed to document incidents. For example, staff did not always document when people had seizures to review for potential triggers or patterns in seizures to report to healthcare professionals.

The provider failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service. The provider failed to ensure the service performance was evaluated and improved. This is a breach of regulation 17 of the Health & 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

- There was not a consistent person-centred approach across all the clusters. Documentation we reviewed

for people was not always empowering. For example, a person's documentation stated they 'must be sent to their room as they can upset other residents and staff.' We discussed this with the registered manager who confirmed all care plans were being reviewed.
● Staff we spoke with told us the lack of permanent staff was difficult and although some agency staff worked at clusters for long periods of time, it was 'wearing' to have so many agency staff. The registered manager was aware of this and was trying to recruit new staff but this was a slow process. This impacted on the culture within some clusters.

The provider failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service. The provider failed to ensure the service performance was evaluated and improved. This is a breach of regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Within some clusters staff felt there was a lack of leadership, guidance, process and some staff felt they were not heard. Some staff had raised concerns about the risk of people using the stairs within one cluster. The lift had been out of operation for 8 years, and the registered manager had plans to fix it approved, however staff felt frustrated that this process had taken so long.
● Some relatives told us they were kept up to date about important information regarding their loved one. However, people were not involved in care planning or setting goals or aspirations.
● The provider had collated feedback from staff in March 2023. Some feedback about the service was negative, for example leadership and people management scored the lowest in Kent. Only 35% of staff said they would recommend HF Trust - Kent DCA as a great place to work. There was a plan in place to address some of these concerns, however this was still in the process of being completed.

The provider failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service. The provider failed to ensure the service performance was evaluated and improved. This is a breach of regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

● Although we identified a number of shortfalls during the inspection, feedback from relatives was generally positive. Feedback included, "We are very happy, the staff have really got the measure of them," and "We have always been delighted with the care they have received."

Working in partnership with others
● Staff and the registered manager worked in partnership with other professionals to meet people's needs. For example, people had referrals to the mental health team, occupational therapist and GP.

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 registered manager understood their responsibilities to comply with the duty of candour. The registered manager told us that when and if something went wrong, they would be open and honest with relevant stakeholders.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed.