HF Trust Limited

HF Trust - St Teath Site

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?	Good

Summary of findings

Overall summary

HF Trust – St Teath Site is a residential care home for up to ten people with a learning disability or autism. There are two properties on one site: Rendle House and Valley View. Each can accommodate up to five people. At the time of the inspection nine people were living at the service. The service is part of the HF Trust group who run a number of residential, supported living and domiciliary care services throughout Cornwall, and nationally. This announced comprehensive inspection took place on 19 September 2018. We last inspected St Teath on 17 and 20 June 2016, when the service was rated Good.

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

The service is required to have a registered manager and there was one in post. 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.

The service was operating in line with the values that underpin 'Registering the Right Support' and other current best practice guidance. This guidance includes the promotion of the values of; choice, independence and inclusion. The service was working with people with learning disabilities that used the service, to support them to live as ordinary a life as any citizen. People had access to private spaces and were able to choose where they spent their time. Staff supported people to access the community regularly. People's independence was respected and they were encouraged to develop and maintain skills.

The service requires a registered manager and there was one in post. 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.

People were protected from identified risk. Staff were aware of the support people needed to help keep them safe. Any changes in people's behaviour or health was monitored to try and identify causes and triggers. Action was taken to learn from any untoward events.

The premises were clean and largely well maintained. People had access to safe outdoor spaces. Any maintenance was carried out quickly and there was a programme of redecoration in place. People's bedrooms were personalised and reflected their tastes and interests.

There had been a high level of vacancies at the service with a large number of agency staff being used to ensure people were supported according to their care plans. A recent recruitment drive had been successful

and, at the time of the inspection, there was only one staff vacancy. Planned rotas showed people were to be supported by a consistent staff team. Each site had their own distinct staff team which was overseen by a senior support worker. Key workers had responsibility for monitoring individual delivery of care. Relatives told us key workers were very familiar with people's needs.

There had been a high level of medicine errors at the service, over a prolonged period of time. We looked at systems for the management and administration of medicines and found there were suitable arrangements in place, including when people went for days out or weekends away. Training was regularly refreshed and there was a system of competency checks in place. We concluded the mistakes were due to human error. We have made a recommendation about ensuring the environment is calm when staff are administering medicines.

Staff were supported by a system of induction, regular training and supervision. They told us they felt well supported by the registered manager and higher organisation. HF Trust had a clear set of values in place which were well known by staff.

People were supported in line with the legislation laid down in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were in place for specific decisions to show when people were unable to make decisions for themselves. DoLS applications had been made appropriately and the any decisions made on people's behalf was made following the best interest process.

People were comfortable and at ease with staff. Some people needed additional support to move around. Staff were patient and kind when providing this support and people were relaxed and confident with them. Relatives told us they believed their family members were safe and well supported by staff who knew them well and understood their needs.

There were quality assurance systems in place to monitor the standards of the care provided. Audits were carried out regularly by the registered manager, and staff and managers from other HF Trust services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Good

The service had improved to Good.
Staff were supported by a system of induction, training and supervision.

The service was working in line with the requirements of the Mental Capacity Act 2005 and related Deprivation of Liberty Safeguards.

Staff worked with other healthcare professionals to help ensure people were supported according to their needs.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

HF Trust - St Teath Site

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 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.

This inspection took place on 19 September 2018 and was unannounced. The inspection was carried out by one adult social care inspector and a pharmacist inspector.

Before the inspection we reviewed previous inspection reports and other information we held about the home including any notifications. A notification is information about important events which the service is required to send us by law. We also reviewed the Provider Information Return (PIR). This 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 looked around the premises and observed staff interactions with people. We met with seven people living at the service, the registered manager, and four members of staff. We looked at detailed care records for three individuals, medicine administration records (MAR), staff training records, two staff files and other records relating to the running of the service. Following the inspection visit we spoke with four relatives and three external healthcare professionals to hear their views of the service.

Good

Is the service safe?

Our findings

People were comfortable and at ease when approaching and interacting with staff. We observed people being supported to move around and they were relaxed when relying on staff to assist them. Relatives told us they had no concerns about people's safety. An external healthcare professional commented; "I find the service capable, safe, supportive and enabling."

A safeguarding policy and information on how to report any concerns was available to staff. The contact details for the local authority safeguarding team were displayed in the office. New staff had safeguarding training as part of the induction process. Staff told us they would be confident raising any concerns both within the organisation and outside if they felt that was necessary. The registered manager told us they would make sure staff were booked on to training as soon as possible. Minutes of staff meetings showed safeguarding was regularly discussed. Staff were aware of their responsibilities to protect people from discrimination and harassment There was a Diversity and Equality policy in place which they were required to read as part of the induction process.

Risk assessments were in place so staff were aware of any identified risk and had clear guidance on how to support people safely. Risk assessments were regularly reviewed and updated as necessary. They were individualised and specific to people's needs. A relative told us their family members mobility had decreased and they were at greater risk of falling. They commented; "Staff know about it and are aware of what to do."

Some people, when anxious or distressed, could behave in a way which might put themselves or others at risk. Staff told us they were confident supporting people at these times and did not need to restrain people. One member of staff told us; "if you keep calm and are firm but quiet [Person's name] will listen." Information in care plans clearly described how to recognise when people were becoming distressed and the actions to take to alleviate this.

The premises were clean. Cleaning equipment was available and any potentially hazardous products were securely stored. Waking night staff completed quiet cleaning tasks in shared areas to help maintain a clean environment. Staff had completed infection control and food hygiene training. They had access to aprons and gloves to use when helping people with personal care.

The boiler, gas appliances and portable electrical appliances had been tested to ensure they were safe to use. There were systems to minimise the risk of Legionnaires' bacteria developing and appropriate risk assessments were in place. Checks on fire safety equipment were completed regularly. Personal emergency evacuation plans had been developed outlining the support people would need to evacuate the building in an emergency. These were detailed and specific to the person.

Water outlets had been fitted with thermostatic mixing valves (TMV's) to control the temperature of water from taps and minimise the risk of scalding. The water temperatures were checked monthly by staff. Records for September showed the temperature from sink taps in some people's bedrooms was above the

advised safe temperature of 43 degrees Centigrade. For example, the water temperature in one person's room had been recorded as 60.1 degrees Centigrade. This had not been highlighted to the registered manager and no action taken to address the fault. Following the inspection, the registered manager sent us evidence to show they had raised the problem with the maintenance team. They assured us they would remind staff of the need to highlight problems to the management team.

We had received concerns about the number of agency staff being used due to staff shortages. The service had been short staffed for a long period of time and had been relying on agency staff to ensure there were enough staff to support people in line with their care plans. Whenever possible these were staff who had worked at the service previously and were familiar with people. The number of staff employed had recently increased and, at the time of the inspection, there was one full time vacancy. Planned rotas for the month following the inspection showed there was never more than one agency worker on shift at any one time. Staff and relatives told us the impact of this was already evident with a more consistent staff team in place. Staff were optimistic the situation had stabilised. Comments included; "At one time I would ring to ask about [relative] and I couldn't be sure of speaking to staff who knew them. That hasn't happened recently" and "Staffing has improved and the new ones have stayed."

Each site had two distinct staff teams with a senior member of staff heading each team. The registered manager explained this consistency of staff was important to people and helped them to feel safe and secure. They commented; "Everyone in Rendle House has autism and routines are important to them."

New staff were required to complete a number of pre-employment checks before starting work. This included Disclosure and Barring Service (DBS) checks and supplying suitable references. This meant people were protected from the risk of being supported by staff who were not suitable to work in the care sector. The registered manager worked closely with a recruitment agency to help ensure new staff were aware of the expectations and demands of the role. They told us this had been successful and staff retention had improved with only two members of staff leaving in the previous 12 months.

At our previous inspection we found systems for the management of medicines were not robust. Medicines that needed to be returned to pharmacy for disposal were not stored appropriately and Medicines Administration Record (MAR) charts were not fully completed. Daily and weekly audits had failed to identify these shortcomings. We had received a large number of notifications in respect of medicine errors over the 12 months prior to the inspection. Due to the concerns a pharmacist inspector supported the inspection.

People's medicines were generally managed safely. However, we have recommended that the way in which medicines are administered is regularly reviewed to check that they are being given in as safe a way as possible.

Staff gave people their medicines and recorded them on medicines administration records (MAR). We checked seven people's current MAR which showed that people were given their medicines correctly in the way prescribed for them. There were protocols for medicines prescribed to be given 'when required' to give staff information on when it would be appropriate to give doses of these medicines for each person.

We saw one person receiving a dose of their medicine at lunchtime in a safe way. The registered manager had made changes to how medicines were given in one house. Further changes were being put in place in other parts of the service to try to reduce distractions and create a quieter and calmer environment to give medicines safely. It was to early for us to evidence if these changes had reduced the pattern of errors and would be effectively embedded.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines. There were arrangements for medicines requiring extra security and refrigerated storage if needed. Storage temperatures were monitored to make sure that medicines would be safe and effective. When people leave the service, for example for days out or weekends, then there were systems in place for making sure medicines were suitably labelled with directions and that they were signed in and out of the home.

Staff recorded the application of creams or other external preparations on the MAR, and there was separate guidance on body maps to show staff where these products were to be used. Prescribed dietary supplements were also recorded on MAR. Most MAR were printed by the supplying pharmacy. However, we saw hand-written changes on two people's MAR where these had not been signed and checked by a second trained member of staff. This is recognised good practice to reduce the risks of any transcribing errors and is also required by the home's medicines policy.

Staff had received training on the use of the medicines system and were checked as competent to administer medicines safely. The registered manager explained the system of competency checks after staff had first been trained to make sure they were safe to give medicines. These checks were updated yearly or after any retraining or any incidents. Further training from the pharmacy had been booked to take place in a few weeks' time.

There were detailed policies and procedures, and information for each person's individual medicines to guide staff on looking after medicines safely. There was a reporting system so that any errors or incidents could be followed up to help prevent them from happening again. Daily medicines check sheets were being completed and weekly checks were also made to make sure these had been completed. As a result of some recent incidents the supplying pharmacy and the medicines optimisation team from the CCG had been to the home to review medicines management. They had made some recommendations which had been, or were being put into place. An external healthcare professional commented; "The system and procedure they follow is sensible so the mistakes may be due to anxiety in the staff."

We concluded most of the reported errors were due to human error rather than any general faults in how medicines were managed. We recommend that improvements to the environment, where medicines are administered, are put in place to help ensure a quiet and calm setting and minimise the risk of staff errors. We recommend this is regularly reviewed to check that medicines are being given in as safe a way as possible.

People's monies were secured securely and individually. Records of expenditure and accompanying receipts were kept and these were audited regularly. Staff had detailed guidance on how to record transactions.

Staff were clear about their responsibilities to raise concerns, record any safety incidents and report them to the management team. One member of staff outlined the action they would take if anyone had a fall. This would include completing body maps, recording the incident on the on-line system and highlighting it to the registered manager. Any incident records were also available to HF Trust's senior management team to review. Incidents were audited regularly to enable any trends to be identified and action put in place to mitigate the identified risk.

Good

Is the service effective?

Our findings

At our previous inspection in June 2016, we found staff were not receiving regular supervision in line with HF Trust's policies and procedures and we made a recommendation regarding this. At this inspection staff told us they were well supported. Records showed staff received one to one supervision regularly, either from the registered manager or a senior support worker. Supervision meetings were an opportunity to raise any concerns, highlight training gaps and discuss individuals support.

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.

There was a comprehensive range of capacity assessments in place in respect of specific decisions regarding people's care and support. For example, we saw capacity assessments regarding whether people should wear harnesses when travelling in a vehicle, the use of an electronically controlled gate and in respect of medicines. There was evidence of best interest meetings involving staff, families and relevant professionals when decisions were taken on people's behalf. An external healthcare professional told us; "[They] work very well with professionals in being well aware of best interests, least restrictive practices."

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS authorisations had been made appropriately. When people's needs changed resulting in changes to the restrictive practices in place this was recorded and the DoLS team were informed.

People were supported to access external healthcare services for regular check-ups. For example, they attended GP and optician appointments and had annual health check-ups. When it was difficult to get people to appointments because of their particular needs the registered manager worked with other professionals to ensure the person received the health support they needed. This was done in line with legislation to ensure any decisions were proportionate, necessary and in the person's best interest.

Staff had the appropriate skills, knowledge and experience to deliver effective care and support. New employees had an induction when they started working for the organisation. For those new to care this included completion of the Care Certificate. The Care Certificate is a national qualification designed to give those working in the care sector a broad knowledge of good working practices. There was also a period of shadowing more experienced staff. The registered manager told us they spent at least one full day with new staff to go through elements of the Care Certificate and organisational working practices. This also gave them an opportunity to get to know the new employee and establish a working relationship.

Training identified as necessary for the service was updated regularly. Apart from some gaps in safeguarding

training most staff were up to date in all areas. We identified one member of staff who had not updated their training since their induction. We discussed this with the registered manager who assured us they would remind the staff member of the need to complete refresher training in line with the appropriate timelines. Staff told us the training was effective and useful, particularly the face to face training. One commented; "The training is actually really good, [trainers name] makes it really fun, it's not boring."

Most relatives told us they believed staff were competent and skilled. One relative told us they felt the service was not specialised enough to meet people's complex needs. HF Trust support people who may have a learning disability or autism. Staff were provided with autism training which was accredited by the British Institute of Learning Disabilities. A behavioural specialist was employed by HF Trust who could work directly with services to develop bespoke training around people's specific needs.

People were assisted to eat a healthy and varied diet. When necessary, referrals to Speech and Language Therapists (SALT) were made; for example, when people had been identified as being at a higher risk from choking. We saw one person eating a meal. Staff were present but unobtrusive and the person was able to finish their meal in their own time which they were clearly enjoying. People were weighed regularly so staff would be aware of any potential problems in this area.

Care and support was delivered in line with the principles underpinning 'Registering the Right Support' and other good practice guidelines. Both sites were distinct settings with their own staff team and dedicated senior support worker. People had access to private spaces, living areas and bedrooms which were personalised and reflected people's personal taste and interests. There were enough bathrooms to accommodate people's needs and ensure people were able to bathe when they preferred. The kitchens were large and people could choose whether to eat together or separately. Both sites were in a state of good repair. Some decoration was taking place at the time of the inspection to improve a staff sleep in room and develop a sensory room. Shared areas were spacious and there was a choice of areas where people could spend their time.

Technology was used to benefit people and promote their independence and autonomy. For example, one person had a fingerprint recognition lock on their bedroom door which allowed them to access the room independently and protect their privacy. Another person loved taking long baths. Because of their health needs this needed to be closely monitored to ensure their safety. A buzzer was fitted in their bathroom so staff could quickly summon assistance if needed. Everyone had tablet devices to promote their communication and choice making.

Adaptations and equipment had been put in place to help ensure people's diverse needs were met. For example, a bath lift had been installed so one person with a physical disability could continue to use the bath safely and comfortably.

Good

Is the service caring?

Our findings

People were relaxed and at ease with staff. We observed staff supporting people to go out and sitting with people while they watched television or ate a meal. The atmosphere was friendly and staff chatted with people while they supported them. An external healthcare professional described staff as; "Very caring" and a relative told us; "I've said to [staff members name] "Don't ever leave will you." It's nice for [relatives name] to build a relationship with staff and it's also nice for us to be able to build a relationship."

Staff told us they enjoyed their work. Comments included; "I really like working with the people, especially [Person's name]. He's always happy, singing and dancing, and that makes me happy." Staff were patient and understanding when supporting people. One person was anxious about what they were going to be doing later in the day. This was making it difficult for them to focus on the present. Staff reassured the person they would talk about their plans later and helped them to bring their attention back to what was happening at that time. The member of staff had to repeat this several times and were gentle and caring in their approach. They clearly knew how to reassure the person and what would work for them.

People were supported to maintain and develop their independence. Personal goals were identified with people and they were helped to work towards achieving these. Staff were working with one person to develop their skills to enable them to move into a supported living setting and live more independently. The goals were broken down into small steps so they were easier to tackle and progress could be more effectively measured and monitored. For example, one goal was for the person to apply topical creams independently. Staff recorded when the person had used the pump mechanism to deliver the cream, dabbed it on themselves, rubbed it in with and without prompts.

People's privacy and dignity was respected. The registered manager told us; "We respect that people need personal and private time." Staff explained how they gave people as much privacy as possible when supporting them with personal care whilst ensuring they were safe.

People's individual anxieties were well known to staff and they supported people to try and avoid stressful situations and alleviate any anxiety. For example, one person found disruption to the environment difficult to cope with. The fire alarms were due to be updated and this would normally involve a series of tests running over the course of the day following each update. Staff had predicted that this was likely to be a distressing experience for this person. They had arranged that the alarms be fitted but not tested until the person had gone out for lunch to minimise any stress.

Staff knew people well and had an understanding of their communication needs and styles. There was a range of communication aids in place and staff used various techniques and approaches according to the individuals' preferences. Everyone had electronic tablet devices and these could be used to facilitate conversation and choice. The registered manager told us; "[Person's name] is very reliant on that system and staff knowing her." Some people used sequence strips and pictorial time tables to help them understand what was happening during the day. Social stories were used to support understanding of specific social situations such as attending health appointments. Some people used simple signing and we

observed staff respond to this appropriately. Staff had received training to help them engage with people effectively. For example, training in basic Makaton sign language, intensive interaction and sensory training had been provided.

Care plans held information about people's histories and backgrounds which had been developed with the support of families. This information is important as it can help staff develop an understanding of the events which have made people who they are. It can also help staff to initiate conversation with people that is meaningful and of interest to them.

Staff recognised the importance of family relationships and worked to support them. One person had recently lost a close family member. Staff had supported them to attend the wake and had spent time talking to the person about their relative. The registered manager told us; "We will talk to them about [family member] and look at photos."

Good

Is the service responsive?

Our findings

Care plans outlined people's needs over a range of areas including their health and emotional well-being. There was information about what was important to and for people and their likes and dislikes. Staff had clear guidance on how they could support people with their emotional well-being as well as their health needs. There were detailed descriptions of people's routines where this was important to them. This included information about what people could do for themselves and what they needed support with. The plans were relevant and up to date. Some sections of the care plans had been produced using pictures and limited simple text to make them more accessible for people. For example, a 'Who am I' document included information about people's likes and dislikes and what was important to them.

Daily logs were used to describe the support people had received during the day, record the activities they had taken part in and any additional information about their emotional well-being. Any changes in needs or how care and support was delivered were recorded and care plans updated accordingly. Monitoring records were in place for some people who had specific health care needs. These were consistently completed. This allowed staff to quickly identify if there was a change in this aspect of the person's health.

Staff told us there were effective systems in place to help them keep up to date with any changes in people's needs and how planned care was delivered. Communication books and individual diaries were used to exchange and record information. Verbal handovers took place between shifts and MARs were kept appropriately.

End of life care plans had been developed with some people and their families. These included information about funeral plans and where and how people would be preferred to be cared for at this period of their lives.

People were supported to take part in activities. One person had a voluntary job at a nearby stables where they also had riding sessions. Other activities people took part in included swimming, local walks, aromatherapy sessions and attending a day centre.

The service was based in a rural area close to a village. People regularly went into the village to the local shop, café and pub. Each site had a mini bus available for use. Staff and relatives told us people had access to a range of opportunities. If necessary taxis were used and one person sometimes used public transport. A relative commented; "He's out most days at least once." One person was due to go on holiday the week following the inspection. They had been supported to choose a holiday using their electronic tablet to look at alternatives. The registered manager told us; "Her loves are music and warmth and this will provide both."

All adult social care providers are legally required to provide people with information they can access and understand in line with the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss. Care plans documented peoples' communication needs. There was information

on whether people required reading glasses and any support they might need to understand information. For example, one care plan stated; "Use short sentences or one worded answers." Hospital passports had been developed to share with other healthcare professionals if people needed to access services. These included an overview of people's health needs and information about people's preferred styles of communication.

There were systems in place to manage and investigate any complaints. A complaints policy outlined the time periods within which complaints would be addressed and responded to. There were no on-going complaints at the time of the inspection.

Good

Is the service well-led?

Our findings

Regular audits and checks were carried out. The registered manager carried out monthly audits of the service which were backed up by quarterly visits from the regional manager. These helped to identify any areas for improvement. HF Trust nationally has developed a model of support entitled 'Fusion' which is underpinned by Person Centred Active Support (PCAS). PCAS is a way of supporting people so they are engaged in meaningful activity. HF Trust registered managers from across the region carried out regular PCAS observations at other services, including St Teath, to help ensure the model was embedded in practice. The registered manager commented; "We are very PCAS orientated."

The service requires a registered manager and there was one in post at the time of the inspection. 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.

The registered manager demonstrated a sound understanding of each individual's needs in their conversations with us. It was clear they were committed to helping to ensure people had a good quality of life and were supported to set and achieve individual goals.

The service was organised in line with the Registering the Right Support guidelines. As outlined in 'Effective', Valley View and Rendle House operated as two distinct sites with dedicated staff teams and senior support workers overseeing the delivery of care in each service. People were encouraged to access the local community visiting shops and using the facilities regularly.

There was a system of clear roles and responsibilities within the staff team. The registered manager was supported by two senior support workers, one based in each site. An external healthcare professional told us; "I do believe the management is good, accessible and supportive." Each site had a distinct staff team to provide consistent support. There was a key worker system in place. Key workers had oversight of named people's care plans and appointments. Relatives were positive about the key worker role and told us they knew their family member well. Comments included; "[Key worker's name] has got [person's name] best interests at heart and would go out of her way for her."

The service worked with other agencies to help ensure people's changing needs were met. One external professional told us; "They are quite pro-active and work very well with professionals." Some external professionals felt staff lacked confidence at times. Comments included; "We have had to give high levels of advice to manage standard risk situations" and "The team seek advice often but it is not always clear if this is due to them feeling not confident in their own decision making." We discussed this with the senior regional manager for HF Trust. They told us they directed services to seek very clear advice when working with other agencies to ensure they were completely clear about their expectations.

Staff told us morale was improving since the recruitment of new staff and new staff said the team had been

welcoming and supportive. One member of staff commented; "Some staff have been there for a while and some are new, we are gelling together. There are some differences in approaches but we will help each other and give each other advice. Everyone is open to new ideas." Team meetings took place regularly. These were used as an opportunity to formally discuss individuals' care planning arrangements. Staff were able to raise any issues or make suggestions about how the service could be improved.

Staff rights under the Equality Act 2010 were protected. For example, HF Trust had developed a kit for staff to use when completing training if they had dyslexia or other related needs. This contained coloured film to assist with reading, dictionaries and magnifying sheets to use with MARs. If staff had any specific health needs risk assessments were developed to help ensure they were supported to carry out their roles effectively and safely.

Action was taken to learn from any events and develop the service to meet people's needs. For example, when it was identified that one person's behaviour was changing monitoring charts were introduced to try and identify any triggers. Staff were guided to; "Record any episodes to explain what she was doing beforehand, what happened during the event and what happened after…..so we can see if there are any patterns such as when strangers come into the house."

The registered manager was pro-active, open and transparent in their approach. They informed CQC of any significant events in a timely manner. CQC ratings from the last inspection report were displayed at the service and on the website.

Records were stored securely to help ensure confidential information was kept private. The records were up to date, accurate and complete. All care staff had access to care records so they could be aware of people's needs.