HF Trust Limited

HF Trust - St Teath Site

Inspection report

Trehannick Road
St Teath
Bodmin
Cornwall
PL30 3LG

Tel: 01208851462
Website: www.hft.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

About the service
HF Trust – St Teath Site is a residential care home for up to 10 people with a learning disability and/or autistic people. The site consists of two separate houses, Rendle House and Valley View. Each can accommodate up to 5 people. At the time of the inspection 9 people were living at the service.

People's experience of using this service and what we found

Right Support:
The service did not support people to be independent and have control over their own lives.

People did not have fulfilling and meaningful everyday lives. They were not consistently supported to set goals. When goals had been identified there were no clear pathways to help people achieve their aims.

People's opportunities to take part in activities and pursue their interests in their local area were limited. There was a lack of variety in the activities offered both in the service and in the community.

People's individual needs and preferences were not always considered when administering medicines.

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.

The environment in one of the houses was in need of updating. There were plans in place to make improvements.

Right Care:
The service did not have enough appropriately skilled staff to meet people's needs and keep them safe.

Staff had not completed training in communication techniques for people who did not use words to communicate. There were very few pictorial tools in use to support people's understanding.

People's care, treatment and support plans were out of date and contained repetitive and irrelevant

information. Although a manager had started to review these, progress was slow as they were in the service infrequently.

People did not receive care that supported their needs and aspirations, was focused on their quality of life, and followed best practice.

The service did not give people opportunities to try new activities that enhanced and enriched their lives.

Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture:
There had been a lack of consistent leadership and oversight at the service. Staff practice was not monitored, and staff were unclear where to go for guidance and support on a daily basis.

Staff meetings and supervisions had not been in place for all staff which limited their opportunity to raise concerns and ask questions.

Staff had not received training or information in relation to best practice and the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. There was a culture of doing 'for' rather than 'with' people.

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 13 October 2018).
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At our last inspection we recommended that the provider ensured staff were able to administer medicines in a calm environment in order to mitigate the risk of human error. At this inspection we found improvements to the way in which medicines were administered were still required.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

The provider had taken steps to mitigate the specific risks which led to the incident. We found no evidence during this inspection that people were at risk of harm from this particular concern.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for HF Trust – St Teath Site on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, risk management, safeguarding people from potential abuse, person centered care, consent, staffing, notifying the commission of significant events, duty of candour and governance.

We have made a recommendation about ensuring the environment meets people's sensory needs and supports their emotional well-being.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

HF Trust - St Teath Site

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors 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.

Service and service type
HF Trust - St Teath Site is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. HF Trust - St Teath Site is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 not a registered manager in post. The provider was taking steps to recruit a manager.

Notice of inspection

This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 used all this information to plan our inspection.

During the inspection
We met with all the people who lived at St Teath. We spoke with 4 agency staff and 10 permanent staff including the regional area manager, an area support manager, the residential operations manager, the acting deputy manager and an acting senior. We reviewed 4 people's care plans, medicine records, daily notes, rotas' and a range of records relating to the management of the service such as policies and procedures. We spoke with 6 relatives and received feedback from 4 health and social care professionals.

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.

Staffing and recruitment

- Managers told us recruitment was particularly difficult at HF Trust – St Teath. The service was short staffed and relied heavily on agency staff to enable them to provide care and support in line with commissioned hours. These were not always achieved and impacted on people's opportunities to experience meaningful days of their choosing.
- People were often supported to go out as a group or in pairs due to the low staffing levels. This meant their individual preferences were not always taken into account. A member of staff told us one person rarely went out because they would not be interested in any of the activities other people took part in.
- The low staffing numbers impacted on people's day to day lives and their opportunity to develop their own routines and preferences. In order to relieve pressure on staff starting work in the morning, night staff at Valley View sometimes got people out of bed as early as 5.30am in order to complete personal care tasks. One member of staff told us; "In the morning (day staff) like people to be up so it's easier on day staff. I have got them up at 5, 6, 7. They don't mind it, they're just used to it." This was evidence of an institutionalised culture in the service.
- Relatives voiced concerns about staffing levels. Comments included; "I can't say I know any of them due to the high turnover of staff" and "Over the last 6 months I have been concerned about [Name's] day to day care due to the high turnover of staff and use of agency staff."
- On the day of the inspection Valley View was staffed by 3 agency staff. One had worked at the service many times, one had worked there a handful of times and the third had never worked there before.
- Staff confirmed Valley View was predominantly staffed by agency staff. No-one living at Valley View used words to communicate which meant it was particularly important they were supported by staff who knew them well and were able to understand what people were communicating.
- Staff skills did not always match the needs of people using the service. Agency staff and most of the permanent staff had not completed training for autism awareness.

The failure of the provider to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff recruitment processes were followed to make sure staff were suitable to work in the care sector. For example, references were obtained and Disclosure and Barring Service (DBS) checks completed before new staff started work. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

At our last inspection we found there had been a high level of medicines errors. We recommended improvements to the environment where medicines were administered, were put in place to help ensure a quiet and calm setting and minimise the risk of staff errors. We also recommended the way in which medicines were administered be regularly reviewed to check they were being given in as safe a way as possible. At this inspection we found the frequency of medicine errors had reduced. However, medicines administration practices still required further improvement.

● The provider could not be sure medicines were being administered in a safe way. In one of the houses everyone received all their medicines mixed with yoghurt to make them easier to swallow. This was not in line with manufactures instructions and the practice had not been checked with a pharmacist to ensure the efficacy of the medicines would not be impacted.
● People had been prescribed medicines to be used as required (PRN). Some PRN creams were being used daily rather than as prescribed.
● Monthly medicines audits had not been completed contrary to the organisations policies. A manager told us the acting deputy would be completing these in the future but had not previously been aware of the need for them.
● Staff had not consistently responded appropriately and in a timely manner when medicines errors were made.

Systems had not been established to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the service contacted a local pharmacist to check there was no negative impact on any of the medicines being taken with yoghurt due to the way they were administered. The provider told us staff had been retrained and appropriate processes were being followed when medicines were administered.
● Protocols for PRN medicines were in place to guide staff on how and when they should be used.
● Staff had completed training in the management of medicines. Training was underpinned by competency checks when staff were observed administering medicines by a senior member of staff. However, not all staff had received an annual competency check as planned.
● People did not receive their medicines in a way that met their preferences. Everyone went to the kitchen, to sit in the same chair so staff could administer their medicines. There were plans to install medicine cabinets in people's bedrooms so people could take their medicines in private when appropriate and safe.

Assessing risk, safety monitoring and management
● Staff checked the temperature of fridges and freezers and water each day and recorded these. However, they did not know what safe temperatures were and so would not know when to escalate concerns.
● Fire checks were completed including checks of extinguishers and fire alarms. A fire evacuation drill had been completed in March 2022. Two people had refused to leave the building. Their Personal Emergency Evacuation Plans (PEEPs) had not been updated to reflect this risk.
● Grab bags were in place for use in an emergency. In one of the houses these were stored in a locked boiler room and so were not easily accessible and did not contain any information that would help staff manage an emergency situation. PEEPs did not contain detailed information about the support people might need to leave the building.
● In Valley View there was an electric extension lead hanging from a wall. No-one was able to tell us if the socket was still live and a potential risk to people's safety.
● One person was at high risk of falls and wore protective head gear at all times. The soft helmet used at

night was not referred to either in the person's care plan or in their falls risk assessment.
● This person was also at risk of poor health due to their low weight and were regularly weighed. However, their weight records had not been transferred to a monthly overview document since March 2022. This meant any pattern of weight loss might have been overlooked.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This contributed to the breach of Regulation 12(Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● There was no system in place to monitor, record and review any use of restrictions on people's freedom. Therefore, opportunities to reduce restrictions could be overlooked. Following the inspection, the residential operations manager provided copies of restriction mapping tools which staff were starting to complete. This would provide an overview of the restrictions in place.
● Incidents and accidents were recorded with details of any actions to be taken to try and minimise the risk of untoward events reoccurring. However, information was not always accurate. For example, following a medicines error when one person had been given too much medicine, an incident form had been completed. The incident was described on the form as 'self-injury.' No action had been taken to try and identify why the mistake had occurred.

The failure to keep accurate and complete records contributed to the breach of Regulation 17 (Good governance)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received further training in supporting people at mealtimes. Everyone living at the service had been assessed by the Speech and Language Team (SALT) and had their eating and drinking assessments updated.
● Staff told us they knew how to support people with food and drink and how to minimise any risk of choking.

Systems and processes to safeguard people from the risk of abuse
● Staff told us they knew who to raise concerns with inside and outside of the organisation. Some staff told us they were not confident safeguarding concerns had always been dealt with by managers.
● Staff received training on how to recognise and report abuse as part of their induction and this was refreshed annually.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the

premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● The service was facilitating visits for people living in the home in accordance with government guidance.

Inadequate

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 inadequate: This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

- Everybody living at HF Trust – St Teath Site had restrictions in place in order to keep them safe. One person had a DoLS authorisation in place, but this had expired in September 2022. The relevant local authority DoLS team told us they had not received an application to renew the authorisation. Following the inspection, the residential operations manager found the application had been submitted to the wrong email address.
- Three further applications had been made to the local DoLS team and assessed as low priority. No applications had been made for the remaining people. This meant restrictions placed on 5 people had not been imposed lawfully.
- Mental capacity assessments did not evidence how people had been supported to receive and understand information when their capacity was assessed.
- Some records indicated there were low expectations for people's ability to be involved in the decision making process. For example, even though people were able to make day to day decisions, one person's record stated; "[Name] lacks capacity in all areas of life."
- Assessments of people's capacity had not always been completed, when necessary. One persons' care records described how they were supported with a specific aspect of personal care. The document stated there needed to be a capacity assessment and best interest process in place around this practice. None had been completed.

People were not supported in accordance with the MCA and associated DoLS legislation. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were not being supported in line with best practice as laid out in CQC's statutory guidance Right support, right care, right culture.
● People were not consistently supported to identify goals. When goals had been identified there were no clear pathways to support people to achieve their goals. There was no information on skills teaching to guide staff on how best to effectively support people to develop their independence.
● People were not always included in decisions about how they spent their time. We observed a member of staff tell one person what they were going to do. They did not ask the person if the plans were appealing to them or offer any choices.
● As outlined in safe, people were not able to develop their own routines in line with their personal preferences due to low staffing levels.

The failure to ensure care was appropriate and met people's needs and preferences was a breach of Regulation 9(Person centered care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Not all staff had completed training to give them the necessary skills and knowledge to support people with a learning disability and autistic people. Training in this area was planned for the near future.
● Agency staff working at the service did not all have a good understanding of best practice in learning disability services. The service was reliant on agency staff and there was very little oversight of their practice. This had a negative impact on people.
● Staff were not regularly receiving supervision, only two members of staff had received supervision since May 2022. This meant staff might not have the opportunity to discuss any working practices or raise concerns.
● There were no systems in place to check staff's competency to ensure they understood and applied training and best practice.
● There was no manager based at the service. An acting manager was in post but there was a lack of managerial support for staff. One member of staff told us they were unsure of all the tasks that needed to be completed.

The failure to provide staff with the necessary support and training to enable them to carry out their roles contributed to the breach of Regulation 18(Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Training in areas other than learning disability and autism was completed.
● New staff completed an induction which covered the fundamental standards. These are standards established by CQC which providers must adhere to in order to ensure quality, person centered care.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people had been identified as being at risk from dehydration. One person's care plan stated they needed to have a certain amount of fluid each day to mitigate the risk of harm. The amount of fluid the person was having was not consistently recorded. Amounts were not totalled at the end of the day meaning staff would be unaware if the person was not drinking enough to keep them healthy.

This contributed to the breach of Regulation 12(Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were not being supported to be involved in choosing their food, shopping, and planning their meals. A member of staff told us they planned the menu for people, saying; "They will eat anything, they all eat together."
● One person's care plan stated the person should be involved in meal preparation. We observed this person sitting in the kitchen while staff prepared their lunch. There was no attempt to include them in the process.

This contributed to the breach of Regulation 9 (Person centered care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All staff had received additional support and training to enable them to support people with eating and drinking.
● Relatives told us they had no concerns about how their family member was supported with meals. Comments included; "[Name] has food allergies and a food chart. It is detailed in the care plan" and "[Name] is at risk of choking and has eating guidance in place. When I found out about the incident I wanted to know if they have changed their practice. I spoke to a manager over the weekend and felt reassured."

Adapting service, design, decoration to meet people's needs
● HF Trust – St Teath Site comprised of two houses, Rendle House and Valley View. Rendle House is purpose built and owned by HF Trust Limited. Valley View is a rented property. Parts of Valley View were in need of updating, particularly shared areas. There were plans in place to make improvements.
● Information for staff was displayed in kitchen areas, this did not create a homely environment.
● People's own bedrooms were personalised. Some of the furnishings were tired and in need of updating.

We recommend the provider seeks advice and guidance to ensure the environment is developed to meet people's sensory needs and emotional well-being.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● One person was encouraged to attend an exercise class weekly and do daily exercises at home.
● People were supported to attend annual health checks, screening and primary care services when needed.
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate: This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Support was not focused on people's quality of life outcomes and people's outcomes were not monitored or adapted according to their changing needs or preferences.
- Care plans were repetitive and much of the information was out of date and no longer relevant. For example, one person had moved into the service in 2019. Their care plan referred to their previous service as if they were still living there. Another stated the person followed a dairy free diet, staff told us this had not been the case for approximately four years.
- We observed a culture of staff doing 'for' people rather than 'with' them. Some people did not communicate verbally but there were limited tools in place to support them to be involved in their care planning and decision making.
- People had limited choice and control over their day. Staff told us low staff numbers could impact on how people were supported. One commented; "It's easier (for staff) to come in and make a cup of tea for someone, it can take ages to support [Name] to do it themselves, and if you're struggling to get things done…"
- People were not supported to complete many tasks around their home. Staff in Rendle House told us people did not do their laundry. One person's goal was to become more independent but there was no guidance for staff on how to engage the person in doing their laundry.
- Staff described how people in Valley View had their medicine administered. This was not according to individual preferences and did not take account of people's individual needs.

This contributed to the breach of Regulation 9 (Person centered care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A manager from another HF Trust location had started a review of care plans and identified some areas which needed updating. However, they only planned to visit the service one day a week and this had not always occurred due to poor driving conditions.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Some people did not use words to communicate. Staff had not received training in the use of alternative communication techniques.
● One member of staff told us; "I had some training in Makaton (a simple signing system) ages ago. It would be useful to have it again. [Name] knows a few signs, it would be good for staff to know them as well, get him to use them more maybe."
● Some people had stickers on their bedroom furniture to show what type of clothing was kept there. The stickers were not always picture based and would not have been meaningful for people. This suggested they had been put in place to aid staff. Furthermore, they were unsightly and detracted from a homely environment.

This contributed to the breach of Regulation 9 (Person centered care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Relatives were unsure if people were being supported to take part in activities they enjoyed. Comments included; "[Name] enjoys being out and about. I think they are going out, there has not been much contact recently. They don't tell me what [Name] is up to, it would be nice. It's over a year since I got any photos", "[Name] used to go swimming. Not sure if they do now" and "Since their keyworker left we have had no feedback so don't know if they are going out."
● During the inspection we observed people were frequently unoccupied and were not being encouraged to take part in meaningful activities and staff did not engage regularly with all people. When we asked at 11am what people were doing that day, staff told us someone was going to their parents' house at 4pm and someone else would go along for the drive. No other plans had been made with people.
● Daily notes showed people rarely took part in individual activities outside of the service. People usually went out in pairs or as a group and there was a lack of variety in the activities offered. Staff told us they went out for drives or walks. If one person needed to be driven somewhere it was accepted practice to take someone else 'for the drive.'

This contributed to the breach of Regulation 9 (Person centered care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Relatives told us they would raise complaints if they felt they needed to although they were unclear who in the service would be the appropriate member of staff. Comments included; "It would have to be [named senior carer], I don't know anyone else there. No idea if there is a manager there" and "I would ring Head Office rather than approach the house."
● There were two ongoing complaints. These were being dealt with in line with HF Trust policies.

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.

Promoting a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people

- The culture in the service did not promote people's individuality or enable them to develop and flourish. We found some practices were institutionalised. People were frequently supported as a group, not as individuals, this was accepted as normal practice. Due to low staffing numbers, night staff were getting people up very early in order to provide them with personal care before day staff started their shift.
- We found indicators of a closed culture. The service was not operated in line with good practice or the ethos and values of the organisation. For example, practices described in safe and responsive in relation to the administration of medicines and financial arrangements were outside of HF Trust policy.
- Staff spoke of a poor culture within the service. They told us concerns had not been listened to or acted on.
- The care provided did not reflect the underpinning principles of Right support, right care, right culture. The model of care used at the service did not promote people's independence or choice.
- The service did not have clear leadership to empower staff or people to achieve positive good outcomes. Staff told us there had been a lack of leadership. Comments included; "I just wish they could move some managers around to give us some top down support" and "It hasn't been great without a deputy manager or registered manager as there is no-one there who can support and give guidance."
- Relatives were unsure who was managing the service and therefore, who they could raise concerns with. Comments included; "It feels like there is no one to report things to", "I don't know who the present manager is" and "I don't know who the manager is. [Relative's name] keyworker told me they had changed manager by phone 4 weeks ago."
- There was no oversight of the culture in the service, either at a local or organisational level. No observations of practice were taking place to ensure staff behaviours reflected the organisations ethos and values. No surveys had been organised to capture the views of families.
- Daily logs were in place to evidence how people spent their time. These were not always completed. There was limited information about what people had enjoyed and what worked well for them.

The failure to continually asses, monitor and improve the service was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Following a notifiable safety incident, the provider had contacted the family to offer a verbal apology and

express their regret.
● No written apology had been given at the time of inspection. This was contrary to the regulations and the organisations policy which state information about the incident and an apology should be provided in writing as soon as practicable following any notifiable safety incident.

This was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was a lack of oversight of the service. There was no manager in place at the time of the inspection. A registered manager from another HF Trust location had been visiting once a week. On a day to day basis an acting deputy manager and acting senior were organising shifts and monitoring the service. However, they did not have the relevant skills, training and knowledge to effectively manage the service.
● Governance processes were not effective. Care plans were out of date and audits of medicines and accidents and incidents were not taking place.
● Confidential information was seen on worktops in shared areas in both houses.
● A quality assurance officer from the local authority had visited the service and developed an action plan to drive improvement. Neither the acting manager or the acting senior had seen the action plan which meant limited action had been taken.
● Policies and procedures were overdue for review.

The failure to establish systems to effectively oversee the service contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. We noted an incident dating back to 2020 which had not been notified to us as well as more recent events indicating this had been the situation for some time.

The failure to notify CQC of notifiable incidents was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and their families were not involved in the development of the service. Families had not been asked for their views with no survey being circulated during the past year.
● Relatives told us communication was poor. Comments included; "Communication is always at my instigation, at every annual review I said I would like a monthly update of bullet points telling me what [Name] has been doing of significance", "[Name's] keyworker left over a year ago, she used to send me messages. Then the next one left and I don't know if [Name] has one now" and "The keyworker was a point of contact, it was easy. Now we've lost it."
● Care plans had not been regularly reviewed.
● A staff meeting had been held shortly before the inspection, but this was only attended by four members of staff. Records showed the previous staff meeting took place in February. The residential operations manager told us they believed there had been more but could not locate any meeting minutes.

The failure to seek and act on feedback from stakeholders in order to evaluate and improve the service

contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The provider had failed to deliver improvement in the service. The lack of oversight and monitoring of the service meant there had been no focus on people's experience of living at HF Trust - St Teath Site.

● Staff told us the organisation had failed to support the service and commit to driving improvements. When asked about management oversight one commented; "It's been one bad decision after another. This site is in trouble, it can't stay the same, it breaks my heart."

● The service was in the process of updating the care planning system to make it more streamlined and easier to navigate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The Commission had not been notified of all incidents specified in the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not act in accordance with the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not consistently assess risks and do all that was reasonably practicable to mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not acted in accordance with the Duty of Candour.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified staff to meet people's needs. Staff had not received appropriate support to enable

them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care of service users did not consistently meet their needs or reflect their preferences.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the registered person to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We issued a warning notice.