HF Trust Limited

HF Trust - Phillippines Close

Inspection report

Phillippines Close
Edenbridge
Kent
TN8 5GN

Tel: 01732782700
Website: www.hft.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
HF Trust - Philippines Close is a residential care home providing personal care to people living with a range of learning disabilities. Some people were also living with physical disabilities and/or autism. The service can support up to 16 people in two separate houses, each of which have separate facilities and is set on a site which is shared with a day service, offices and supported living accommodation owned by the same provider. On the day of our inspection, there were 14 people living at the service, seven people lived in each house.

People's experience of using this service and what we found
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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Although the service was able to demonstrate people received the right care. Shortfalls in the delivery of values, attitudes and behaviours of leaders meant they were not delivering principles underpinning right support and right culture.

Right support:
The model of care was not in keeping with the principle of right support. The service was laid out across multiple buildings, in a campus-based set up. Before the national lockdown people were being supported to access the community, the local town and café to ensure local links to the community were encouraged, but people would benefit from a review of the service against the guidance

Right care:
• Care that was provided was person-centred and promoted people's dignity, privacy and human rights

Right culture:
The lack of leadership within the service lead to a poor culture and staff did not feel confident to raise concerns to the management team. This meant the service could not demonstrate the principles underpinning right culture. The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services led confident, inclusive and empowered lives.

Although staff were able to tell us how they would recognise signs of abuse and where to report it, they did not feel confident in the management team that their concerns would be listened to. Some staff had received training in safeguarding, but new staff employed that were working alone, had not received any. The provider had reported to the local authority safeguarding team and investigated when there were safeguarding concerns raised.

Dependency tools used did not identify how much time was needed to support people. This meant that the registered provider was unable to say confidently that there were enough staff to support people. Staff we spoke with gave mixed feedback about the staffing levels and felt people missed out on meaningful activities during the pandemic due to limited staff availability. Relatives we spoke with felt there was a high staff turnover and there were not enough staff to meet people's needs. Safe recruitment practices were followed.

Although personal protective equipment had been put in place throughout the service including the entrances, staff had come through one of the houses and into the office without putting a mask on. Although no staff were observed providing care to people without masks on, government guidelines state suitable facemasks must be worn at all times. We addressed this with the management team during the inspection. Staff were reminded of the guidance and interim management was put in the service to monitor staff practice.

Lessons were not learnt when things go wrong. Although staff filled out accident and incident reports when they occurred, management had failed to analyse them in order to take appropriate action and learn when things went wrong.

There were shortfalls in the quality monitoring of the service to ensure people were safe and their needs were met. Staff lacked clear guidance and leadership from managers. Safety checks of hot water outlets were not carried out for a period of two months and lack of oversight meant this was not picked up quickly. Staff had missed out on regular supervision and lacked confidence in the management team.

Risk assessments were in place for people and gave guidance for staff to follow to reduce risks. This included risks relating to Covid- 19 for both individuals and staff.

Medicines were managed safely and procedures were being followed by staff.

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 20 January 2020).

Why we inspected
We received information of concern about peoples' care and safety and in relation to the leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe 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.

Since the inspection the provider has sent us their interim plans to manage the service until a new manager

is in post.

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 coronavirus and other infection outbreaks effectively.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to regulation 18, the provider had failed to have an effective system in place to order to deploy staff. Regulation 13, the provider had failed to respond appropriately to allegations of abuse. Regulation 12 and Regulation 17, the provider had failed to assess monitor and mitigate risks to people and to assess monitor and improve the service.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

HF Trust - Phillippines Close

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 Care Act 2014.

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 assistant inspector. One of the inspectors supported the inspection off site by reviewing documents.

Service and service type
HF Trust - Philippines Close is a 'care home'. 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 did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We attempted to make contact with the service from the car park but were unsuccessful. We checked the Covid-19 status before the inspection took place.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We requested feedback from the local authority and safeguarding team, however, they did not have any recent information to share. The provider was not asked to complete a provider information return prior to this

inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people and eight members of staff including the operations manager. We observed interactions between staff and people. We looked at a range of records including medicines records, three people's care records and staff employment records. We reviewed records off site that had been sent to us by the provider. These included a variety of records relating to the management of the service including quality assurance documents and staff supervision records.

After the inspection
We continued to review records and seek further clarification from the provider in some areas. We spoke with three more staff and six relatives. We also had a feedback meeting with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There were not always were enough staff to meet people's needs. A dependency tool was used to assess staffing levels however, this had not always effective to determine when staffing levels needed to be increased. This meant the provider could not always be assured they had the correct number of staff available.

● Relatives we spoke with felt there were not enough staff to meet people's needs. One relative said, "There's has been a very high turnover of staff recently and there's not enough staff." Another relative said, "The staff tend to leave more often than stay, they rely heavily on agency staff."

● One to one time had been allocated for people using the service. We observed one person's one to one time and found there was minimal interaction between the staff member and the person. Staff fed back to us one to one time did not always happen or the time was used for other tasks. This meant that people missed out meaningful engagement that was important to them.

● Staff told us people were affected with things such as meaningful activities now the day centre was closed. This was because staffing levels had not been increased to ensure extra support in this area could be given in replacement of time spent in the day service.

Registered persons did not have an effective process in place to deploy sufficient staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely following the organisations policy and procedure. Pre- employment checks were satisfactorily completed for all staff before they began working at the service. These checks included two references, full employment history, right to work in the United Kingdom and Disclosure and Barring service criminal records checks (DBS). The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

Learning lessons when things go wrong.

● Lessons were not learnt, and improvements were not made when things had gone wrong. Accident and incident forms had been completed by staff when an incident had occurred however, these had not been viewed, signed off or analysed by a member of the management team. Six of the last eight incidents were awaiting review by a manager. Multiple incidents had occurred where a person had become distressed and because the incidents had not been reviewed, they were at continued risk of psychological harm. Records did not indicate what action had been taken to reduce reoccurrence.

Registered persons had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of regulation 12(Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff knew how to identify signs of abuse and where to report them if they had concerns. However, when staff had reported concerns to the management team they had not always been acted on. This put people at continued risk of harm and abuse. Staff were not confident in raising concerns with the management team.
● Some safeguarding concerns had been recorded and reported to the local authority. Where these concerns had been reported action had been taken. However, this had not always taken place consistently.
● Safeguarding policies were in place and were due for renewal. Records showed 20 percent of staff had not received safeguarding training, this included a new member of staff that had been working alone in the service without supervision.

Registered persons had failed to respond appropriately to reports of abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives we spoke to told us they felt their relative was safe. Comments included, "Yes very safe, no problems what so ever"; "Oh yes very, we used to get in touch with the house manager if needed to discuss something."

Preventing and controlling infection
● Records evidenced that it had been identified during a staff meeting in October 2020 that staff had not been wearing the required personal protective equipment (PPE) in relation to masks. During this inspection we observed staff walking through the service without wearing masks. This caused an increased risk to people and staff of contracting coronavirus.
● Staff told us the provider ensured they had plenty of PPE. They were kept up to date with government guidance through policies and procedures. However, appropriate use of PPE was not always observed on the inspection.

Registered persons had failed to assess the risk of, and preventing, detecting and controlling the spread of infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were not completely assured that the provider was using PPE effectively and safely. Staff were wearing face masks on shift and around people using the service. However, we identified staff that were starting the afternoon shift coming into the service into the office without wearing masks. The provider took action during the inspection, it was addressed with staff and interim management was put in the service to ensure oversight.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was clean and tidy. Staff were observed during the day performing cleaning tasks. Increased cleaning of touch points had been introduced. This was to help the spread of coronavirus.

● 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.

Assessing risk, safety monitoring and management
● Risk assessments were in place for people and identified individual risks. Care plans included what staff needed to do to support people. Staff knew where to find risk assessments and felt they included information they needed, including new risk management around Covid-19.
● The provider had ensured regular checks were carried out for electrical and gas safety. Certificates were in place after safety checks had been carried out.
● The provider had put a general risk assessment in place for covid- 19. This was to help minimise the risk of contracting and spreading the virus amongst the staff, people and visitors using the service. This includes guidance for staff to follow and includes when staff need to isolate.

Using medicines safely
● Medicines were managed safely. Trained staff administered people's medicines in accordance of the company's policy. We observed staff supporting people to take their medicines and followed correct protocol.
● A weekly medicine administration and storage check was in place. This monitored the stock levels of people's medicines for the forthcoming week to reduce the risk of them running out. The check also identified any gaps in the medicine's administration record and whether any medicines needed to be returned to the pharmacy.
● Medicines were stored safely in people's rooms. Locked cabinets were used to ensure safe storage and temperature checks were carried out regularly. A separate medicines trolley was used to safely store stock which was in a locked room. Medicines requiring additional storage were stored and managed safely following current regulations.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of effective leadership within the service. Staff lacked clear direction from the management team. Comments included, "No I don't feel it is well managed, there is a general lack of communication"; "I'd say it is 40% well managed, there is poor communication and only the 'favourite' staff get told information."
- There were shortfalls in the quality monitoring of the service to ensure people were safe and their needs were met. For example, a quality assurance audit completed by the area manager in September 2020 identified shortfalls in the lack of staff supervision and annual appraisals throughout the year 2020.No action had been taken to address this shortfall. A health and safety audit in July and August 2020 identified some weekly checks continued to not be completed; no action had been taken to address these shortfalls.
- Lack of management oversight meant that the provider had failed to identify shortfalls in essential health and safety checks. Hot water checks had not been carried out for a period of two months although this had been re- commenced. Lack of oversight meant there was an increased risk that people could have been harmed through the use of hot water.
- The service did not have a registered manager in post, they had left the service on 09 November 2020 . Interim management arrangements had been put in place, however on the day of inspection the acting manager was shielding due to covid-19. No other arrangements had been put in place to cover the service until after our inspection when concerns were raised with the provider.
- Staff had not been consistently supported to develop and receive feedback in their role. There had been a lack of supervisions or role modelling good practice from the management team. Comments included, "Supervisions only happen when staff really push for them"; "I've tried to express my concerns, but nothing happens, so I have decided to keep quiet"; "We have team meetings, but the problem is we are never involved in the agenda, the agenda is always set and we don't get to talk about areas we wish to discuss."
- Staff told us they didn't get asked to feedback through surveys. One staff member told us, "Families are sometimes given surveys, but staff aren't, the problem is here management don't treat staff the same, equality and diversity is a big problem."
- No feedback requests had been sent to relatives this year due to the covid- 19 pandemic, but we reviewed an analysis from 2019. No concerns were highlighted however, no other feedback was received from people, staff or professionals. This meant we could not be assured people were encouraged to be engaged and involved with the running of the service.

The registered persons had failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (2)(a) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider understood their role and regulatory responsibility. They understood that important events such as death had to be reported to the Care Quality Commission (CQC). Notifications had been made appropriately.
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had clearly displayed their rating on a notice board within the service and the provider had displayed the agencies rating on their website.
● A person who lives within the community at HFT was a chosen representative who helped gain feedback from people. They visited people regularly to get general feedback regarding various things, such as house décor, food etc. Feedback was also sought during spot checks of care and support. The spot checks were carried out by the operations manager .
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had failed to promote a positive culture within the service. Although we observed good interactions between staff and people, staff told us the morale was low. Comments included, "The morale is very, very low"; "It depends who is here if management is not here it's ok"; "It depends what house you work in, house [number] is very, very bad, it has affected all of us including residents."
● The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. This was due to the campus style set up of how the service was laid out. Lack of general management and oversight of the service meant that there was a poor ethos and culture within the service.

The registered persons had failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (2)(a) (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
● The provider knew their responsibilities under the duty of candour. They had policies in place to ensure they were open and transparent when things went wrong. Although the previous manager had failed to act on safeguarding concerns raised, the provider responded quickly when they were aware of the concerns.

Working in partnership with others; Continuous learning and improving care
● The provider had started working in partnership with the local community nurses during the Covid-19 pandemic. The nurses visited weekly and regularly reviewed a variety of people's needs and supported staff where necessary. They also provided staff with some training.
● Prior to the pandemic the service had started working with the local authority safeguarding team. This was to make sure the local authority safeguarding team could be involved with regular meetings to help the provider and staff team learn from mistakes. Unfortunately, this had been cancelled because of the pandemic but they were hoping to start this again when possible.
● People were encouraged to set goals and discuss what was important to them. One person wanted to learn how to cook again. This was a recent goal and the service was looking at ways to make this happen.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Had also failed to assess the risk of, and preventing, detecting and controlling the spread of, infections. Regulation 12 (1)(2)(a)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons had failed to respond appropriately to reports of abuse. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The registered persons had failed to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered persons did not have an effective process in place to deploy sufficient staff to meet people's needs.