HF Trust Limited

HF Trust - St Teath Site

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
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
Staff had identified goals for people and these had been included in care plans. However, there had been little progress in moving towards achieving these goals. Information on how to support people with appropriate skills was not available.
Daily logs were not consistently used to record what had worked well for people and what had not gone as well. There was limited information about people's quality of life outcomes. This meant opportunities to learn from people's experiences might be missed.
People's individual interests were known and, when possible, staff supported them to do the things they enjoyed. However, opportunities were sometimes impacted by staffing arrangements.
People had a choice about their living environment and were able to personalise their rooms.
Improvements were being made to the environment at Valley View and more were planned.
Staff enabled people to access specialist health care support in the community.
Staff supported people with their medicines in a way that promoted their independence. However, there had been a series of medicine errors.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The provider was investing in technology to enable restrictions in place to be reduced.

Right Care
Staff did not consistently respect people's privacy and dignity.
There were not enough contracted staff to meet people's needs and keep them safe. To mitigate this the provider had invested in regular use of agency staff. Although some agency staff were 'block booked' and worked at the service regularly, others were at St Teath less frequently. This did not ensure people received consistent care from staff who knew them well and who had built trusting relationships with them.
People's communication preferences were known by staff. However, tools to support communication were

not always in place.
People's care, treatment and support plans had been updated to better reflect their range of needs.
The service worked with other agencies to protect people from potential abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture
There was a new manager at the service. They were receiving daily support from the local residential operations manager and further support from HF Trusts divisional Head of Care and Support - West.
Additional support from external agencies and professionals had been sought to try and drive improvements in the service.
Training in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have was being rolled out to contracted staff and regular agency staff.
The high dependence on agency staff had impacted on many aspects of the service. Challenges for the service meant managers had to prioritise where they focused their efforts, often having to spend their time on rota management. This impacted on their opportunities to monitor the service.
Feedback from professionals and relatives was that, although improvements had been made there were still areas where work needed to be done.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 22 February 2023).

At our previous inspection we identified breaches in relation to person centred care, implementation of the Mental Capacity Act, safe care and treatment including in relation to the administration of medicines, risk management and safety checks at the service, oversight and management of the service, staffing levels, a failure to follow Duty of Candour policy and a failure to notify CQC of events as required by law.

We issued 2 warning notices in relation to the breaches of person centred care and management of the service. At this inspection we found the warning notices had been partly met although we still had concerns. We met with the provider who agreed to provide monthly action plans and reports to demonstrate how they were working to address the concerns.

We also made a recommendation about the environment. At this inspection we found improvements to the environment had been made and more were planned.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care, staffing and management of the service.

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 remains 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 always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
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 2 inspectors, a member of the CQC medicines team, 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. A new manager had been in post for 6 weeks, they told us they intended to submit an application to register.

Notice of inspection
The 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 12 agency staff, 1 member of relief staff, 2 permanent staff and the manager, deputy manager, the residential operations manager and HF Trusts' Head of Care and Support - West. We reviewed 4 people's care plans, medicine records for 4 people, people's daily notes, rotas, training records 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 with experience of the service.

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● Despite a recruitment drive the service remained highly reliant on agency staff. This meant people were not always supported by staff who they knew and trusted and who had a good understanding of their needs.

● Since the previous inspection only two new care staff had been recruited. One agency staff worker told us; "We're all agency trying to help other agency, trying to do our best between us."
● At the time of the inspection there were 5 contracted full time staff in post, and 14 full time vacancies. On the first day of our visit there was only one HF Trust member of staff supporting people. On the second day there was one full time HF Trust member of staff and a relief member of staff working at the service with other roles being filled by agency staff. Rotas showed this was not unusual.
● Managers told us they tried to use a regular group of agency workers when possible. We looked at planned rotas for the two weeks between 10 April and 23 April and saw there were 37 different agency workers on the rotas. This meant people were not consistently supported by staff they were familiar with and had built trusting relationships with.
● Arrangements were in place to provide regular agency staff with HF Trust training where possible. However, due to the large numbers of agency staff working at St Teath this was not always feasible.
● Some agency staff told us there was a lack of guidance and information available to them and they were not always sure of their responsibilities. Although one page profiles had been created for each individual outlining essential information and do's and don'ts, agency staff told us they had not seen these.
● Relatives were also concerned about staffing levels and the impact on people. Comments included; "There are a lot of agency staff now, I don't see how they can get to know [Name]" and "An agency staff member advised me they had been block booked for 6 weeks. It is not possible for an agency staff member to get to know [Name's] routines and ways in that time as it takes several weeks before [Name] starts to feel comfortable with new staff."

This was a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some agency staff were block booked in advance and had worked at the service regularly. These agency staff told us they were kept up to date with changes in people's needs.
● There were plans in place to focus on recruitment in the local area. One new member of staff was due to start work shortly after the inspection and another 2 applicants had been invited for interview.

Using medicines safely

At our last inspection the provider had failed to establish systems to ensure the safe and proper management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Staff recorded when people's medicines were administered on Medication Administration Record (MAR) charts. This also included the application of creams and other external preparations. These records showed that people's medicines had not always been administered as prescribed for them. Two medicines were out of stock. Doses had been missed as they had not been reordered in a timely way.
● New MAR charts had been introduced to make directions clearer and to record who had transcribed and checked them. However, one previous chart was in use, which had been handwritten and the full directions had not been recorded on it. The handwritten chart was not produced in accordance with the provider's policy and did not record when prescribed medicine breaks were to be taken.
● Where medicines were prescribed 'when required' then there were detailed and person-centred protocols in place to guide staff when these might be needed. The times of administration for these medicines were not always recorded leading to the risk that doses could be given too close together.

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

● There had been some medicines errors and incidents. Most of these had been identified through regular checks and audits and reported and investigated. Some improvements had been put in place and the number of incidents were decreasing. Staff, including agency staff now had training and competency checks.
● Medicines were stored securely, and there were suitable arrangements for any medicines needing cold storage.
● Medicines audits took place, and some areas needing improvement had been identified. A new audit tool had recently been introduced to try to improve the way medicines were managed within the service.
● Since the previous inspection, arrangements for the storage of medicines had been changed so people could take their medicines in private when appropriate and safe.

Learning lessons when things go wrong

At our last inspection the provider had failed to keep accurate and complete records. This contributed to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Incidents of concern and accidents were recorded and analysed to try and identify patterns and ways of mitigating risk. One person's daily notes made references to them, hitting themselves 'with force.' These events had not been recorded as incidents and there was limited detail on the circumstances leading up to the incidents. This meant opportunities to learn may have been missed.

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

● Following an occasion when one person had been left without personal care, managers had reviewed how shifts were organised to mitigate the risk.
● Since the previous inspection systems had been introduced to monitor any restrictions in place. This meant managers were able to have oversight and effectively review any restrictions in place.

Systems and processes to safeguard people from the risk of abuse
● A series of concerns in relation to the service had been reported to CQC. In some cases these indicated people had not been respected or supported in line with their care plan.

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

● In some cases staff had reported safeguarding concerns they had directly to managers. These had been addressed and shared with the relevant authorities.
● Staff told us they were more likely to report concerns than they had been previously as they were more confident they would be dealt with appropriately and quickly.
● People were supported with their personal money. We checked the records for one person and found these were accurate.

Assessing risk, safety monitoring and management

At our last inspection we found 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 a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Health and safety checks were in place to maintain oversight of utilities. For example, water temperature checks were completed and checks of fridge and freezer temperatures. At the last inspection we identified there were some gaps in these checks. At this inspection we again found temperature checks of fridges and freezers were not consistently completed. When the temperature fell out of the expected range action had not been taken.

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

● Risk assessments had been updated to reflect people's current needs.
● There were risk assessments in place in respect of the environment, including fire safety. Fire evacuations

had been completed recently. Staff told us they would like to see these done more regularly due to the variations in the staff team.
● A member of staff had responsibility for overseeing health and safety. They told us they had recently completed a course to support them in this area.

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.

● There were no restrictions on visitors at the time of the inspection.

Requires Improvement

Is the service effective?

Our findings

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

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

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

At our last inspection the provider had failed to ensure people were protected from the risk of poor hydration. This contributed to a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Due to the high numbers of staff deployed who may not have understood people's needs well it was particularly important that accurate records were maintained.
- Some people were at risk of poor hydration and had their fluid intake monitored. We found monitoring charts had not been consistently completed or totaled. For example, one persons fluid monitoring form stated their intake should be 2100 mls per day. The record only recorded 3 cups of tea of 300 mls each were drank at 4.00pm, 6.00pm and 9.00pm. This poor recording meant any risks of dehydration could be overlooked.

This contributed to a repeat breach of Regulation 12 (Safe care and treatment) 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

At our last inspection the provider had failed to ensure care was appropriate and met people's needs and preferences. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- Staff had worked with people to identify goals and these had been included in their care documentation. There was no evidence of any move to progress towards these goals and limited detail about the required skills pathways.
- The steps towards achieving goals focused on what staff needed to do rather than how people could be

involved at each stage.

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

● Since the previous inspection the service had started working with other agencies to ensure assessments of people's communication support and sensory needs were in place. This work was ongoing at the time of this inspection.
● Support plans were being reviewed and updated to more accurately reflect people's needs and aspirations, included physical and mental health needs.

At our last inspection the provider had failed to support people to be involved in their own support at mealtimes. This contributed to a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9 in this area.

● Mealtimes were flexible to meet people's needs and to accommodate their individual preferences. One person had recently chosen to eat alone and this routine had led to them being more relaxed at mealtimes.
● Staff told us they attempted to involve people in choosing and preparing meals. While menus were planned at the beginning of the week people were able to make alternative choices if they wished.
● Some people were reluctant to be involved in preparing food and drinks. Staff told us they encouraged them to do as much as they wanted or were interested in.

Staff support: induction, training, skills and experience

At our last inspection we found the provider had failed to provide staff with the necessary support and training to enable them to carry out their roles. This contributed to a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 18 in this area.

● All contracted staff, and some agency staff, had completed Person Centred Active Support (PCAS) training and this had been underpinned by observations of their practice when supporting people. One member of staff described how this had made them reflect on their practice and provide care in a more person centred way.
● Contracted staff had completed training in learning disability and autism and there were plans in place for others, including regular agency staff, to attend this training.
● Contracted staff had started a course in advocacy which was being provided by a local advocacy group.
● Staff received face to face supervision with a manager. This was an opportunity to discuss training needs and any organisational changes.

Staff working with other agencies to provide consistent, effective, timely care
● The service was working with professionals from external agencies to try and improve people's experience of the service.
● Other professionals told us the service approached them for advice and guidance appropriately. One

commented; "There is a trusting relationship between our team and the staff team and they do seek help from the team and have open communication with us."

Adapting service, design, decoration to meet people's needs

At our last inspection we recommended the provider considered guidance to ensure the environment was developed to meet people's sensory needs and emotional well-being.

At this inspection we found improvements had been started.

● Some cosmetic improvements had been made to the environment in Valley View. People had been encouraged to be involved in decisions about the decoration of their personal rooms.
● There remained restrictions in the kitchen at Valley View which had been put in place to keep people safe. The operations manager told us they would be using technology to reduce the restrictions and ensure they were the least restrictive option.
● At our previous inspection we had seen bedroom drawers with unsightly labels on indicating what was in the drawer. These had no value for the people who used the furniture. We saw some of these stickers were still in place. The operations manager told us they had been unable to remove them but the furniture was going to be replaced.
● The interior and decoration of Rendall House was pleasant and had been designed to accommodate people's needs. For example, the kitchen was large with an island so people could be involved with meal preparation. Corridors were wide enough for people using wheelchairs.

Supporting people to live healthier lives, access healthcare services and support
● People had health actions plans and hospital passports which contained basic information about people's needs and communication preferences.
● People were supported to attend annual health checks, screening and primary care services.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection we found 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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, whether appropriate legal

authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Mental capacity assessments had been completed for specific decisions. These detailed the support people had received to help them understand the decision being made.
● For people that the service assessed as lacking mental capacity for certain decisions, best interest decisions had been recorded.
● The service was working with a local advocacy group who were delivering training to the staff team about the importance of advocacy.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- The way in which staff spoke to people and some of the written records was not always compassionate or mindful of their dignity. For example, one person's care records stated; "[Name] can manipulate a situation so they have everyone's attention."
- We heard a member of staff discussing arrangements for one person to go out. They commented; "We will need to change your pad and make sure we take a spare." This was said in a room where there were several other people and members of staff.
- Concerns raised by staff had highlighted occasions when people had not received care and support in a caring or dignified manner.
- One person's activity plan highlighted they needed to be supported to develop a routine. There was no information on what that routine should be.

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

- We saw some examples of person-centred, caring support. Staff were patient with people and took time to listen to them.
- HF Trust staff and regular agency staff communicated effectively with people and demonstrated an understanding of their needs.
- The provider was introducing technology to promote the independence of people using the service
- Staff knew when people needed their space and privacy and respected this.

Supporting people to express their views and be involved in making decisions about their care

- An advocacy group was working with staff to develop their understanding of advocacy and identify ways of supporting people to express their views.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement: This meant people's needs were not always met.

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

At our last inspection the provider had failed to provide personalised care in line with people's needs and preferences. This contributed to a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- The staffing issues meant there were limited drivers available to support people to go out when they wanted to. We observed one person expressing a wish to go to a particular place. Because there was only one driver on duty and some shopping needed to be done they were unable to do as they wanted and went shopping instead.
- Daily notes recorded how people had spent their time. These were inconsistent in quality of information. The daily notes for people living at Valley View lacked detail and were mainly focused on meal times and what people had eaten. There was no information on what people had enjoyed and what had worked well for them.
- Support was not focused on people's quality of life outcomes. Outcomes were not monitored or adapted in line with changes in people's needs.

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

- Daily notes in Rendle House were more informative and contained information about what activities people had enjoyed.
- There were plans in place for agency staff to undertake driving competency assessments to enable them to use the service vehicles.

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.

At our last inspection the provider had failed to take steps to support people's individual communication needs. This contributed to a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People were not always supported in line with their communication needs. A document entitled 'You said we did' stated one person had developed their own signs and these should be documented in a communication profile. The information then noted a member of staff had not been aware of the document in question.
● The same person used a tablet to support their communication. On the second day of the inspection the tablet had not been charged although the person was due to go out on a family visit and would need the device with them.

This contributed to a repeat breach of Regulation 9 (Person centred 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

At our last inspection the provider had failed to ensure people had access to meaningful activities. This contributed to a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had made improvements in this area and was no longer in breach of the regulation in this aspect..

● People were being supported more regularly to take part in activities that were meaningful to them and reflected their individual interests. However, as described above, opportunities were sometimes impacted by a lack of staff who were able to drive.
● Some group activities were taking place outside of the service and staff told us people enjoyed going out together on occasion.
● People did not engage in many activities while they were in the service, especially in Valley View. Staff told us it was difficult to engage with people or hold their interest.
● The environment in Valley View did not support opportunities for staff to engage people in household tasks such as meal preparation or laundry. Plans were in place to reduce restrictions in respect of the kitchen. This would make it easier for people to be supported to take part in activities in the kitchen.

Improving care quality in response to complaints or concerns
● Relatives told us they could raise concerns and complaints easily, one commented; "I know how to make a complaint and have done previously."
● The service treated all concerns and complaints seriously and investigated them in line with organisational policies and procedures.

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 inadequate. The rating for this key question has remained 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-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found the provider had failed to continually assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At our previous inspection we rated the service inadequate and issued warning notices in relation to Regulations 9 (Person-centred care) and 17 (Good governance). At this inspection we found the warning notices had not been met.
● At our previous inspection we reported the service was significantly understaffed and there was a heavy reliance on agency staff. At this inspection we found that, despite a recruitment drive, the service continued to rely on agency staff to deliver care and support.
● Difficulty in recruiting permanent staff had impacted on the service's effectiveness. Managers told us they spent a lot of their time trying to manage the rota and plug any gaps. This meant they were not always visible in the service and able to monitor staff culture and working practices.
● Although there was a core group of regular agency staff this, on it's own, was not enough to provide the staffing levels required and other agency staff were also used to supplement the more regular staff. This meant not all staff were familiar with people's needs and processes within the service. An agency worker told us; "There is hardly ever a senior on shift. They don't have good systems for handing over info."
● A new system to have shift leaders was being introduced. However, this was not well embedded at the time of the inspection. Staff in Rendle House told us there was no shift leader on the day and no-one had been identified as responsible for basic health and safety checks.
● Due to the staffing issues there was a shortage of seniors in place. In order to address some of the associated problems agency nurses were being used to oversee some of the responsibilities a senior care worker would normally have. On both days of the inspection the nurses on site had no prior knowledge of the service. One of them had not previously worked with people with a learning disability or autistic people.
● The provider had increased the oversight of the service. A new manager had been appointed and they were supported by the residential operations manager on a daily basis. In addition, the organisation's Head of Care and Support – West visited the service twice weekly. However, we remained concerned about the

level of support required to deliver the service and the number of continued concerns.

This was a repeat breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The use of technology was being explored to reduce the number of restrictions in place. Training for supporting people with a learning disability and autistic people was being provided to regular agency staff and contracted staff.

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

At our last inspection the provider had failed to act in line with the duty of candour. This was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 20.

● The provider had apologised to people, and those important to them, when things went wrong.
● A relative commented; "I was very concerned about leadership, communication and transparency within the home. It is much improved."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found the service had failed to notify CQC of notifiable incidents. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● The provider had notified CQC of all events and incidents as required by law.
● The manager was being supported to get to know the service, staff team and people living at St Teath.
● Improvements to systems and processes were being introduced. Care plans were being reviewed to help ensure they were accurate and up to date.
● The provider was investing in agency staff by providing them with HF Trust training to help ensure they had the same skills and knowledge as contracted staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection we found the provider had failed to seek and act on feedback from stakeholders in order to evaluate and improve the service. This contributed to a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made in this area.

● Staff meetings had been held to give staff the opportunity to discuss any concerns or make suggestions about how the service was organised.
● Staff had encouraged people to be more involved in decisions about their environment.
● Feedback from relatives about communication with the service was mixed. Most agreed this had improved since the previous inspection. Some felt they were not always kept up to date with organisational news from Head Office.

Continuous learning and improving care
● At our previous inspection we found there had been a lack of focus on people's experience of living at St Teath. At this inspection we found there had been little improvements in this area. Managers had needed to prioritise where they had focused their attention.
● One relative commented "I think they're mainly going in the right direction, but there is still a long way to go."
● Many of the concerns identified stemmed from the staffing issues at St Teath. The provider and managers were aware of the impact this was having and had taken steps to try and address this. However, recruitment remained a challenge.

Working in partnership with others
● Managers and staff had worked with other organisations to tray and improve care and support for people using the service.
● Professionals commented on how managers had been open and transparent with them when discussing the challenges at the service.
● The service had been pro-active in seeking out support from other agencies and professionals.

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 9 HSCA RA Regulations 2014 Person-centred care Care and support did not always meet the needs of service users or reflect their preferences.

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance with the regulations.

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.