HF Trust Limited

HF Trust - Milton Heights

Inspection Report

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Summary of findings

Overall summary

HF Trust – Milton Heights is a service for up to 33 people, based in five houses within its own grounds. It provides accommodation, care and support for people with a learning disability. At the time of our inspection there were 27 people living at the service.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We found people were involved in decisions about their care and support, which they discussed regularly with their key workers. They were encouraged to be as independent as they wished to be and were supported to take part in a wide range of activities.

Care and support were provided by a consistent team of care staff who were clear about their roles and responsibilities and knew people well. Staff received appropriate training and had the skills necessary to carry out their roles. They were clear about how to identify, prevent and report abuse and worked in cooperation with the local safeguarding authority.

People told us they were happy living at the service and they felt safe. They told us they would know who to go to if they were “worried” or “frightened” about anything and said they were confident staff would always help them.

When we asked staff about people’s needs, they were able to provide up to date information about all aspects of people’s care and support. Staff made appropriate referrals to other professional and community services. A healthcare professional from the Community Learning Disability Team told us staff were “always very helpful, provided all the necessary information and sought advice when required”.

During conversations with people, we found staff spoke respectfully and in a friendly way; they adapted their vocabulary appropriately and took time to listen. People attended ‘house meetings’ to express their views about the service and took part in a ‘parliament’ which promoted people’s interests.

Throughout our inspection, staff spoke positively about the service and told us it was well-managed and well-led. We found senior staff promoted a positive culture that was centred on the people who used the service.

Where people were unable to make decisions themselves, we saw decisions were made in their best interests and in accordance with the relevant legislation. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

We spoke with the local safeguarding authority, who told us they were concerned about a number of incidents where people using the service had hit other people using the service. We found several of these incidents had occurred in one house and the service had taken appropriate action to prevent further incidents.

Providers are required to report such incidents, which are a form of abuse, to CQC. However, we identified five incidents which had not been reported to CQC.

Medicines were managed safely for most people. However, we identified concerns with the management of some medicines in one of the houses and with storage arrangements for medicines that needed to be kept at cooler temperatures in all the houses.

You can see the action we have asked the provider to take can be found at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People were kept safe because risk assessments were comprehensive, up to date and protected people appropriately from identified risks.

People we spoke with told us they felt safe. They said they would know who to go to if they were "worried" or "frightened" about anything. They told us they felt confident staff would always help them.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the location was meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff had been trained to understand when an application should be made, and how to submit one.

We found, in most cases, people were protected from bullying, harassment, avoidable harm, abuse and breaches of their human rights. There had been seven incidents where people using the service had been hit by other people using the service since the beginning of January 2014. However, no injuries had been caused and the service had taken positive action to prevent further incidents from occurring.

We found in most of the houses people's medicines were managed safely. However, we identified concerns with the management of some medicines in one of the houses and with the security of storage arrangements for medicines that needed to be kept at cooler temperatures in all the houses. This meant there had been a breach of the relevant legal regulation.

You can see the action we have asked the provider to take can be found at the back of this report.

Are services effective?

We found the service provided effective care to most people. However, for two people who used the service, care was not always effective.

People were involved in decisions about their care and support, which was delivered in a personalised way.

Summary of findings

People received appropriate support from healthcare professionals when required. People's needs were known and fully met except in one case where the service was awaiting additional funding to allow them to meet the person's needs fully. In another case, we were told that advice from a psychologist was not always followed by staff.

Individual needs were enhanced by the adaptation and design of the houses and grounds of the service. Houses and connecting pathways were maintained in good condition.

People received care from staff who were appropriately trained.

Are services caring?

We found the service was caring; people were treated with dignity and respect and were listened to.

During conversations with people, we found staff spoke respectfully and in a friendly way; they adapted their vocabulary appropriately and took time to listen.

Responses to a recent survey of family members were positive, showing they were happy with the way care and support were provided. People we spoke with were also satisfied that support was provided in a caring way.

Staff at all levels clearly knew the people they were supporting and caring for. They were able to tell us about people's life histories, their interests and their preferences. This enabled them to provide support in a way which was appropriate to each person.

Each person was supported to maximize their independence and lead an active life.

As well as individual meetings to discuss people's care plans, additional opportunities were provided to ensure people's voices were heard. This meant people were able to influence decisions that affected them.

Are services responsive to people's needs?

People were encouraged to make their views known about their care, treatment and support.

People were encouraged and supported to make their own decisions. Where they were unable to make decisions themselves, we found decisions were made in their best interests and in accordance with relevant legislation.

People had access to a wide range of activities, both at the service and within the wider community.

Summary of findings

Complaints were recorded, investigated and resolved appropriately. Investigations were thorough and questioning. This demonstrated the provider responded appropriately to people's concerns.

Are services well-led?

Throughout our inspection, staff spoke positively about the culture of the service and told us it was well-managed and well-led.

The provider's policies on equality, dignity, respect and encouraging people to be as independent as possible were up to date and appropriate for this type of service. We found the principles outlined in the policy documents were reflected in the behaviour of staff.

Incidents and concerns were recorded in a way that allowed staff to identify patterns. The service had systems in place to identify and manage incidents effectively.

Care and support were provided by a consistent team of care staff who were clear about their roles and responsibilities and knew people well. Systems were in place to monitor staffing levels and training.

Staff had the necessary knowledge, skills and experience to meet the needs of people at all times.

The provider had arrangements in place to encourage staff to express their views and identify improvements that could be made to the service. Staff told us this made them feel valued.

Emergency plans, including personal evacuation plans for each person living at the service, were in place and understood by staff.

We found that seven incidents of abuse had been reported to the community learning disability team. We found the service had only reported two of them to CQC as required. This meant there had been a breach of the relevant regulation.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 10 people living at the service. Six people told us they were satisfied with the care and support they received. They described staff as "good", "helpful" and "kind". One person said, "I like living here". Other people, who were not able to communicate verbally, smiled or made positive sounds when asked if they were happy living at the service.

We also looked at responses to a recent survey of family members. Comments included: "Healthcare excellent, love and affection excellent, physical well-being excellent"; "Care – utmost care and compassion are shown at all times"; and "Wonderful facilities and care, very strong relationships with HFT staff giving a real family feel to the home. Endless patience and understanding".

People told us they felt safe and knew who to go to if they were "worried" or "frightened" about anything. They said they were confident they would be listened to and that staff would always help them.

A healthcare professional from the Community Learning Disability Team told us of one person who had been admitted to hospital following a head injury. They said staff "went above and beyond" by attending the hospital for 12 hours a day to act as an advocate for the person and ensure their needs were meet.

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Detailed findings

Background to this inspection

We visited the service on 10 and 11 April 2014. We spent time in each of the five houses at the service observing care and support being delivered. We also spent time looking at records, including people's care records, training records and records relating to the management of the service.

The inspection team consisted of a lead inspector and an Expert by Experience who had experience of learning disability services.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before the inspection we reviewed all the information we held about the service. At our last inspection in October 2013 we did not identify any concerns with the care provided to people who lived at the service.

On the days we visited we spoke with 10 people who used at the service, nine members of care staff and the registered manager.

Following our visit we spoke with a healthcare professional from the community learning disability team who was involved in the care of people living at the service and a member of the local safeguarding authority.

Are services safe?

Our findings

We found people were not always protected from bullying, harassment, avoidable harm, abuse and breaches of their human rights.

We looked at the service's policies on safeguarding and whistle blowing. We saw these were up to date and appropriate for this type of service. Staff records showed all staff had received training in safeguarding and that this training was refreshed annually. We spoke with three members of staff who were clear about how to identify, prevent and report abuse. One staff member showed us a reference card they carried at all times with key information about the Mental Capacity Act, 2005 to help them make appropriate decisions.

We spoke with a member of staff at the local safeguarding authority. They told us good relationships existed with the service; the service referred any concerns or incidents to them promptly and was quick to seek advice. However, they told us they were concerned about a number of incidents where people using the service had hit other people using the service. They told us there had been seven such incidents since the beginning of January 2014, although no injuries had been caused. We found positive action had been taken to reduce the number of such incidents, including reviews of the staffing levels, the environment and the support needs of the people involved.

People we spoke with told us they felt safe. They told us they would know who to go to if they were "worried" or "frightened" about anything. They said they were confident staff would always help them. During both days of our inspection we saw people were comfortable spending time in the registered manager's office and talking to senior staff.

We looked at guidance to staff called 'tactile response' which detailed how staff should respond when people sought physical contact. In all but one case, this was personalised to the individual and provided clear guidance to staff to ensure the person was protected from the risk of abuse. In one case, the guidance was not clear; we discussed this with the registered manager and they agreed to review it.

We looked at the service's policy on handling people's money and looked at three people's records for small amounts of cash that staff looked after for them. We saw people's money was held securely in individual wallets. These showed all money received and spent was properly accounted for. Receipts were present for all money spent. A system of signatures, together with security seals on the wallets was used to record all transactions and ensure they were accurate. The system used complied with the provider's policy and protected people from financial abuse.

We looked at risk assessments for five people and found they were comprehensive, up to date and protected people appropriately from identified risks. For example, one person had a safety helmet and we saw the guidance to staff was very clear about when and in what circumstances the person needed to wear it. Another person was at risk working in the kitchen; we saw the kitchen was kept locked and staff were clear about which people were able to access it safely and how the risks should be managed. In one house, two people suffered from epilepsy; we found there were arrangements in place to ensure a member of staff was always present when one of these people was in the lounge, so they could be monitored appropriately. In other cases, specialists had been consulted to ensure people who used wheelchairs or bed rails were able to do so safely.

We found most people's medicines were managed so they received them safely. We looked at the medication administration records (MAR) for six people living in three of the five houses at the service. These showed all required medicines were in stock and people had received their medicines as prescribed. All medicines were held securely.

Staff who administered medicines were appropriately trained and authorised. This ensured staff were competent to administer medicines safely. People's ability to self-medicate was assessed on admission and reviewed regularly so this was only done by people who could do so safely.

Most medicines were supplied pre-packed by the pharmacy. This minimised the risk of dispensing errors by staff. However, a small number of other medicines, such as paracetamol, which were administered 'as required', were supplied in boxes. In one of the houses we inspected, we found the quantity of 'as required' medicines in stock was not recorded on the MAR charts. This meant the provider was unable to fully account for all medicines.

Are services safe?

Clear guidance was in place for the administration of all but one 'as required' medicine. However, in the case of one 'as required' medicine, the instructions were not clear. They specified one tablet per day to be taken "when feet are sore or swollen" but did not provide further guidance to staff to enable them to identify: when the person's feet were sore or swollen; what effect the tablet would have; and what to do if the soreness or swelling did not reduce. This meant the person may not have received their 'as required' medicines in a consistent way.

We spoke with the local safeguarding authority about one person, who was prescribed a rescue medicine to be used in the event of a seizure. They told us they were aware of two recent incidents where the wrong dose of this medicine had been given to this person. In one case they had received too much of the medicine and in the other case they had received too little of the medication. They told us these errors had not had a detrimental effect on the person as they had made a full recovery from their seizures. The registered manager told us that following the errors, staff had placed a hand-written label over the dispensing label to make the instructions clearer. This had prevented further dispensing errors. However, we saw the hand-written label had become worn and was not easy to read, which meant the person remained at risk of receiving the wrong dosage.

We found there were no storage facilities in any of the houses that met with good practice guidance for the storage of medicines that needed to be kept at cooler temperatures, such as liquid antibiotics. Staff told us when they needed to keep medicines cool, they kept them in a locked tin inside one of the domestic fridges. This storage method was not secure and posed a risk that people could gain access to medicines they were not prescribed. No controlled drugs (CDs) were being stored at the time of our inspection. However, suitably secure storage facilities would be required if CDs were prescribed to people in the future.

The above issues meant there had been a breach of the relevant regulation (Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have asked the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

We found the service provided effective, care to most people. However, for two people who used the service, care was not always effective.

People were involved in decisions about their care and support. Staff told us that before people were admitted, they visited the service and spoke with staff and other people living there. These visits took place over an extended period, for gradually longer periods until the person was ready to move in permanently. This process ensured people's needs and preferences could be identified and measures put in place so those needs would be met.

We looked at six care plans and saw the views of people and their families were recorded on admission and during monthly meetings with their key workers. Records of the monthly meetings showed people were able to comment on any aspect of their care and welfare and were able to request changes to the way they were supported. Care plans were centred on the person as an individual. One person showed us their care plan, which they carried with them, and told us they had had input into its drafting. A staff member described the service's approach to people in the house they worked in by saying "It's not an eight person service; it's eight services for eight people". This showed staff understood the principles of personalised care.

Care plans were split into three parts: finance, health, and general care and support. The general care and support plans provided clear guidance to staff about how people wished to be supported, including details of their personal care needs, daily routines and activities. In the health files, we saw people received appropriate support from healthcare professionals when required. Referrals had also been made to specialists, including psychologists, psychiatrists, occupational therapists and physiotherapists. A member of staff from the community learning disability team told us that whilst most interventions were well received, advice from the psychologist at one of the houses was not always followed. They thought this might be due to staff turnover in this house, which meant care and support may not have been provided in a consistent way.

A healthcare professional from the Community Learning Disability Team told us of one person who had been admitted to hospital following a head injury. They said staff "went above and beyond" by attending the hospital for 12 hours a day to act as an advocate for the person to ensure their needs were meet. They told us staff had been particularly good at identifying unusual behaviour in the person and "pushing the hospital to provide the necessary treatment". The healthcare professional also praised staff in other cases, saying they were "always very helpful, provided all the necessary information and sought advice when required". We looked at responses to a recent survey of family members. One comment said, "[The person's] health is always monitored extremely well and her diet is watched". This showed people were supported to maintain good health and received ongoing healthcare support.

When we asked staff about people's needs, they were able to give us up to date information about all aspects of people's care and support. In all but one case, we found, people's needs were known and fully met. We identified one person whose needs had changed and who was unable to access many activities. They expressed a wish to be able to sit in an ordinary chair. Staff told us a physiotherapist and an occupational therapist had advised against this for safety reasons. They had provided a supportive chair, but the person told us this wasn't comfortable, so they chose to remain in their wheelchair. The registered manager told us of action they had taken to secure 'continuing healthcare' funding from the NHS. This had been approved in principle and the person was awaiting its implementation. In the interim, staff were meeting this person's essential health care needs. Staff understood the impact that being confined to a wheelchair had on this person; they said they were hopeful that once 'continuing healthcare' funding was in place, this person's needs would be met more fully.

Individual needs were enhanced by the adaptation and design of the houses. People told us they had been able to choose the decoration of their rooms and we saw most were personalised with photographs and pictures. In the case of one person, we saw their room had been designed around them to accommodate their size and make it as much like their home as possible. Where required, bathrooms had been adapted to make them more accessible; passenger lifts were available and electric bath hoists had been installed. Handrails were provided in communal areas and signs were in a form which would be

Are services effective?

(for example, treatment is effective)

easily understood by people living at the service. People who required supportive chairs and wheelchairs had been provided with them. This enabled staff to meet people's diverse needs.

The service was based in its own grounds, with level access between houses. Houses and connecting pathways were maintained in good condition, which made the grounds accessible to wheelchair users and people with mobility difficulties. We spoke with staff about arrangements for repairing minor faults. They were clear about how to notify faults, such as a dishwasher which broke during our inspection. They told us urgent repairs were fixed quickly, although non-urgent repairs sometimes took longer.

People received care from staff who were appropriately trained. We looked at the induction and training programme for staff. We saw this was comprehensive and ensured all staff had the knowledge and skills necessary to carry out their roles. Records showed the provider's mandatory training was up to date or ongoing for all staff members. Staff told us they thought the training was "excellent" and "spot on". In addition to mandatory subjects, they said they could request additional training courses. These included Makaton specialist communication system, administering emergency medication and 'enabling positive risk taking'.

Are services caring?

Our findings

We found the service was caring as people were treated with dignity and respect and were listened to. One person using the service had died recently, and on the second day of our inspection their funeral was taking place. We heard staff talking about the person with great affection; they told us they felt privileged to have been able to care for the person at the end of their life and to have enabled them to die in the place of their choice. Staff and other people using the service had contributed to the funeral service and the person's end of life plan had been adhered to.

Whilst talking to senior staff in the office, we saw several people each day walk in and help themselves to tea, coffee and biscuits. They were clearly used to doing this and senior staff used it as an opportunity to engage with people and check they were happy.

During conversations with people, we found staff spoke respectfully and in a friendly way; they adapted their vocabulary appropriately and took time to listen. Staff told us they used objects of reference and photographs to aid communication and we saw these in people's care plans. In all but one case, we saw staff knock and wait for permission before entering people's rooms. During an activity session one person indicated they needed the toilet. The staff member indicated the door discretely and while leaving with the person said to others present "Back in a moment".

We spoke with six people about how staff treated and supported them. They told us staff were "good", "helpful" and "kind". We looked at responses to a recent survey of family members. Comments included: "Healthcare excellent, love and affection excellent, physical well-being excellent"; "Care – utmost care and compassion are shown at all times"; and "Wonderful facilities and care, very strong relationships with HFT staff giving a real family feel to the home. Endless patience and understanding". People we spoke with were satisfied that support was provided in a caring way.

Staff at all levels clearly knew the people they were supporting and caring for. They were able to tell us about people's life histories, their interests and their preferences. Positive relationships between people using the service were supported by staff. We were told about one couple who had recently become engaged and one of the people was pleased to show us their engagement ring. Staff told us they were continuing to work with the couple to support the relationship and help them to understand fully the significance of marriage. This would ensure the relationship developed in line with the informed wishes of each person.

People were encouraged to be as independent as they wanted to be. One person had expressed a wish to manage their own medicines. We saw a device had been supplied which dispensed their medicines at set times. If they did not take their medicines, the device sent a message to staff to alert them. We spoke with the person about the device. They told us they were "very happy with it" and said, "It helps me with my independence".

In each house, we saw people were involved in choosing the weekly menus and doing the shopping. Menus were adapted daily to suit the needs of people with special diets. Those who wished to were encouraged to help with the preparation of meals. Staff told us about techniques they had learned to promote people's independence. They said these had proved successful and had led to people being able to make drinks and butter toast. At lunchtime, we saw people preparing food, setting tables and clearing up.

In one house, which had a passenger lift, staff told us how one person liked to travel in it on their own, but needed support when they exited by the stairs. Another person needed a staff member to travel with them in the lift, as they became anxious, but liked to operate the buttons on their own and was supported to do so. Each person was, therefore, supported to maximize their independence.

As well as individual meetings to discuss people's care plans, additional opportunities were provided to ensure their voices were heard. These included house meetings and a 'parliament' that representatives attended to promote the interests of people using the service, both locally and across the provider's other services. The registered manager told us this was a national initiative which the service supported. We spoke to one of the representatives of the parliament and they told us of its achievements. These included introducing new activities, securing additional training facilities for people and meetings with police and councillors to discuss bus stops and the environment. They told us the parliament was a

Are services caring?

“good way to get people to listen to us”. We saw records of house meetings which showed people were encouraged to express their views about the service. This meant people were able to influence decisions that affected them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People were encouraged to make their views known about their care, treatment and support. We saw people held meetings with their key workers each month or sooner if required. Staff told us the meetings were an opportunity to discuss anything concerning the person and to ensure they were happy with care and support being provided. We saw records were kept of the meetings and changes were made as a result; for example, additional activities were facilitated.

The registered manager told us they had difficulties obtaining lay advocacy services locally. Although they had been used to good effect in the past, they were not currently being used. This could limit people's ability to make their views known.

The registered manager also told us the service was exploring the possibility of developing the grounds to create alternative forms of accommodation to better suit some people's needs. People told us they had been consulted about these plans and were looking forward to the opportunities they would present. This meant people's views had been considered.

People were encouraged and supported to make their own decisions. For example, staff told us people chose whether or not to have the 'flu jab' after being given appropriate information in a format they could understand. Other decisions, such as what to wear and eat and what activities to take part in were made with similar support.

Where people were unable to make decisions themselves, due to a lack of mental capacity, we saw decisions were made in their best interests. Records showed these were made in accordance with the relevant legislation and in consultation with family members, care managers and healthcare professionals. One best interest decision we saw related to a person's expressed wish to go on a holiday. They were unable to understand the risks involved or appreciate the amount of money it would cost. Following consultation with relevant parties, and the person themselves, they were supported to go on their holiday. Staff who knew people well also contributed to best interests decisions made by healthcare professionals, such as doctors and dentists. This ensured people's values and wishes would be considered as part of the decision making process.

People had access to a wide range of activities. The service operated a 'flexible support centre' where music, dancing and other activities were provided both to people living at the service and to other members of the community. People told us of other activities they took part in, such as woodwork, pottery and 'come dine with me' events. They also attended activities within the community including yoga, swimming and day trips to a local community centre and other local attractions. One person told us he was being supported to attend a national exhibition which he was looking forward to. People's recreational needs were met appropriately.

We looked at the provider's policy on complaints and saw it included pictorial representations to aid communication. Staff told us people were supported to make complaints in writing or could equally make them verbally. Records showed complaints were recorded, investigated and resolved appropriately. At the end of the process, people were asked whether things had improved. The more serious or significant complaints were recorded on the provider's computer system. The registered manager explained how these were used to identify patterns or themes. They provided an example of a number of complaints relating to footpaths in the grounds that had been washed away by the winter storms. They said they were able to use the complaints records to ensure urgent action was taken to repair the paths.

We also looked at a complaint relating to an allegation against a member of staff. We saw the provider's processes had been followed, in consultation with the local safeguarding authority, to resolve the allegation. The record showed the investigation had been thorough and questioning. This demonstrated the provider responded appropriately to people's concerns.

Are services well-led?

Our findings

Throughout our inspection, staff spoke positively about the culture of the service and told us it was well-managed and well-led. They described management as "supportive" and said they enjoyed working for HF Trust. We found staff were willing to question practices and were supported appropriately when they raised concerns. One example related to the administration of medicines. Staff had been requested to identify and report errors by colleagues and we saw this had occurred.

We looked at the provider's policies on equality, dignity, respect and encouraging people to be as independent as possible. These were up to date and appropriate for this type of service. We found the principles outlined in the policy documents were reflected in the behaviour of staff. Staff repeatedly used the word "support" when talking about how they cared for people. Examples included: "We support [x] to take their medicines"; "We support [y] with their incontinence"; and "[z] is being supported to learn new skills". One member of staff, when talking behaviour that could challenge others, said, "Challenging behaviour is a form of communication; we need to look at the issues and understand why they are displaying such behaviour". The service promoted a positive culture that was centred on the people who used the service.

We discussed recent medication errors with the registered manager. They showed us an action plan they had produced which included a more robust auditing system for medicines. We saw this was in place and being used by staff. Disciplinary action had also been taken against one staff member in line with the provider's disciplinary procedures and the staff member had received additional training. The action plan had led to some improvement, and the issues were being actively monitored.

Care and support were provided by a consistent team of care staff who were clear about their roles and responsibilities and knew people well. There was little turnover of staff, with many having worked at the service for a number of years. When cover was required, the service was able to use a bank of 'flexi' staff who were able to work in any of the five houses. In addition, the service had a contract with an agency who were able to supply staff when cover could not be provided from existing resources. We were told only a small number of agency staff were used, to ensure continuity of care for people they were supporting. Although the number of staffing hours was determined by pre-set allocations on an individual basis, staff told us they were was a degree of flexibility built in to ensure all people received sufficient support at all times.

Systems were in place to monitor staffing levels and training. The registered manager told us of steps they were taking to recruit additional staff. Records of training showed staff had the necessary knowledge, skills and experience to meet the needs of people at all times. At night, staffing levels were reduced to two care staff for the whole service, plus a 'sleeping nights' staff member who could be woken if needed. One member of staff told us they "could do with more on nights", although we did not identify that the reduced numbers had had any adverse impact on people using the service.

The service had a registered manager in post. They were supported by a provider who had access to additional resources. Staff told us there were regular team meetings which provided an opportunity to discuss concerns and suggest improvements. The provider also operated a staff representative group to enable the views of staff from all of its services to be heard. This promoted an open culture and showed staff views were valued.

Emergency plans were in place and understood by staff. We saw each house had a 'disaster plan' in place. This included personal evacuation plans for all people, contact numbers for managers and off-duty staff and information about fire safety. Records showed fire safety equipment was maintained appropriately and fire drills were held regularly. The service operated an on-call rota for senior staff to ensure someone was always available for advice or to attend in the event of an emergency.

We found incidents and concerns were recorded in a way that allowed staff to identify patterns. For example, it had highlighted repeated conflict between people living in one house at particular times. Staff told us of measures that had been taken, as a result of this, to manage and reduce the number of such incidents. These included increasing staff numbers, reducing the number of people living in the house and creating an additional lounge so people were able to spend time in a quiet area. They also ensured there was always a member of staff sat between people at the meal table where the majority of the incidents had occurred. When we visited this house we saw one person

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slap a staff member's hand. The staff member pulled a sad face and asked the person not to slap them. The service was taking appropriate action to identify and manage incidents effectively.

Providers are required to report such incidents, which amount to abuse, to CQC. However, of the seven incidents reported to the community learning disability team, we found only two had been report to CQC. CQC was, therefore, not able to monitor the level of abuse effectively and take appropriate regulatory action. This meant there had been a breach of the relevant legal regulation (Regulation 18(1) & (2)(e) of the Care Quality Commission (Registration) Regulations 2009). You can see the action we have asked the provider to take can be found at the back of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Management of medicines** The registered person had not protected all service users against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18(1) & (2)(e) of the Care Quality Commission (Registration) Regulations 2009** **Notification of other incidents** The registered person had not notified CQC of all incidents of abuse in relation to service users.