HF Trust Limited

HF Trust - Phillippines Close

Inspection report

Phillippines Close
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We held a comprehensive unannounced inspection on 6 September 2018.

At our last inspection, the service was rated 'Requires Improvement' overall and in three of the key areas. There were two breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. The provider had failed to ensure that people's needs were assessed and people's care designed to meet their needs and preferences. The provider had also failed to establish and operate systems to assess, monitor and improve the quality and safety of the service; and failed to maintain accurate and complete records.

At this inspection, we found some improvements to people's needs assessments and a continued breach in the failure to monitor and improve the quality and safety of the service; and maintain accurate records. We identified four further breaches of the Regulations. Therefore, this is the second consecutive time the service has been rated as Requires Improvement.

HF Trust – Phillippines Close is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 16 people in two separate buildings, 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 seven people living in one house and eight people in the other. People had a range of learning disabilities and some people also had physical disabilities, autism or dementia.

Although the service had been built and registered before Registering the Right Support (RRS) had been published, the provider had been developing the service in line with the values that underpin this and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a manager on site who is in the process of registering with CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Safeguarding policies were in line with Local Authority safeguarding procedures, staff had received training and were able to tell us what they would do in the event of a safeguarding concern. However, concerns had not always been reported to the Local Authority and CQC; and acted on by the provider.

People were protected from the risk of infection and were cared for in a clean environment. Risks to people were assessed although some were overdue for review and there was no risk assessment for one person

who can present with behaviour that challenges.

The provider did not consistently ensure the safe use of people's prescribed medicines. Not all bottles had been dated on opening and people did not have protocols in place for all their PRN medicines to ensure people received medicines when they needed them. Medicines were not always stored safely at the correct temperatures in line with the providers policy.

The provider did not always learn from incidents as not all incidents had been reported. Where incidents of behaviour that challenges had been reported, they were not always acted on and therefore lessons were not always learnt when things went wrong.

Safe recruitment practices were carried out by the provider. However, staff had not received regular supervision. The provider struggled to recruit to cover the identified staffing hours required.

The provider had trained and supported staff to understand the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. However, the provider was not working within the principles of the Mental Capacity Act (MCA) 2005. They could not be assured that decisions were made in people's best interest.

Staff worked together and with other agencies to deliver care and people were supported to access the health care they needed. The home had been adapted to meet people's needs, for example around their mobility. People were supported to cook their own meals and told us they were happy with the food provided. People were supported to menu plan and to go shopping. People who had specialist needs around their diets had an eating and drinking assessment completed.

People's views on whether staff were caring were mixed. Staff knew the people they cared for well and we saw positive personal interactions between staff and people throughout the day. People's individual protected characteristics under the Equality Act 2010 were considered. There was a person centred culture and people's rooms reflected their interests. Staff respected and promoted people's needs for independence, privacy and dignity. People were supported to maintain contact with their families and relatives could visit when they wished. Advocacy services were promoted. However, people and their relatives were not always involved in their care.

One person used makaton, but staff were not trained to use it. Makaton is a language programme using signs and symbols to help people to communicate. Information had been provided to people in a way which met their individual needs, however the manager was unaware of the Accessible Information Standards and we have made a recommendation about this in our report.

People's care was not always responsive to their needs as some people didn't have care plans around their behaviour that challenges and staff were not provided with guidance for how to support people with their behaviour that challenges. People's care met their needs around their dementia, epilepsy and mobility and their care reviews were person centred. People knew how to make a complaint and the complaints procedure was on display. People had end of life person centred plans which detailed their wishes.

Assistive technology was used to support people's care where appropriate and people were supported to manage their finances. In line with 'registering the right support' people with learning disabilities were supported to access and be part of their communities and people were supported to take part in activities they liked.

There were auditing systems in place, however these had either failed to identify the concerns we found or the provider had not acted on them. The provider has not shown continuous learning and improvement. Not all care, service and staff records were updated or completed adequately. The duty of candour was not well evidenced as incidents were not always reported and where relevant relatives were not always informed. The provider had not always notified CQC of certain changes and important events that happened in the service.

Staffs views on leadership being available were mixed. Staff and managers were encouraged to complete further training and there was a development pathway for staff. The staff team did not have the opportunity to communicate and meet with each other regularly. Staff were invited to offer feedback and surveys were completed with people and relatives. However, we could not see any evidence of where this had led to any analysis and lessons learnt from the feedback. The provider had built up a partnership with a local school to promote a positive image of working within the care industry and to support the schools fundraising.

During this inspection, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations and one breach of The Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

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.

Safeguarding concerns had not always been reported and acted on by the provider.

Risks to people were not always assessed and kept up to date.

People's medicines were not always managed safely. Protocols were not in place for all 'as and when' required medicines and medicines were not always stored in line with the providers policy.

The provider did not always learn from incidents as not all incidents had been reported therefore lessons were not always learnt when things went wrong.

Safe recruitment practices were carried out by the provider.

People were protected from the risk of infection and were cared for in a clean environment.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity assessments did not evidence how people were supported to make the decision and that decisions made were in their best interest. DoLS applications had been made in line with the legislation.

Not all staff had received training around one person's communication needs. Staff had not received regular supervision.

Staff worked together and with other agencies to assess and deliver care and people were supported to access the health care they needed.

The home had been adapted to meet people's needs, for example around their mobility.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always informed and involved in their day to day care.

People's views on whether staff were caring were mixed. Staff knew the people they cared for well. There was a person centred culture. People's rooms were personal and reflected their interests.

Staff respected and promoted people's needs for independence, privacy and dignity and people's care plans described how to meet these needs.

People were supported to maintain contact with their families and relatives could visit when they wished. Advocacy services were promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans did not include the support they needed with behaviours that challenge.

People were supported to take part in activities they liked and to have holidays.

People knew how to make a complaint and the complaints procedure was on display.

People had end of life person centred plans which detailed their wishes.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Records were not updated or completed adequately. Auditing systems had either failed to identify, had not acted on or failed to make the required improvements.

The duty of candour was not well evidenced as incidents were not always reported. The provider had not always informed CQC of important events that happened in the service that they are required to by law.

Staffs views on leadership being available were mixed. Staff were invited to offer feedback.

The provider had built up a partnership with a local school to promote a positive image of working within the care industry and to support the schools fundraising.

HF Trust - Phillippines Close

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We conducted an unannounced comprehensive inspection on 6 September 2018. The inspection was undertaken by two inspectors.

Before our inspection, we reviewed the information we held about the service including the previous inspection report. We looked at notifications which had been submitted to inform our inspection. A notification is information about important events which the provider is required to tell us about by law.

Due to a technical difficulty we did not request the provider to complete a Provider Information Return (PIR) on this occasion. This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. We looked at this information during the inspection.

We met people who lived at HF Trust - Phillippines Close and observed their care within communal areas. We looked at the interactions between staff and people. We spoke to six people. We inspected the environment, including the laundry, kitchen, bathrooms and people's bedrooms.

During the inspection we spoke to four care staff, a senior support worker, the manager and a senior manager. We spoke with three relatives. We requested feedback but did not receive any from commissioners and a GP visiting at the time of our inspection was unable to speak to us.

We reviewed three people's care records, medicines records, two staff recruitment files, staff induction, training records and a variety of records relating to the management of the service including staff rotas and quality audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found not all people had protocols in place for their 'as required' (PRN) medicines and creams were not dated on opening. We recommended that the registered manager review their processes about PRN medicines and the use of creams.

The provider had not followed our recommendations and at this inspection we found the provider did not consistently ensure the safe use of people's prescribed medicines. Whilst creams had been dated on opening, not all bottles had been dated on opening. People did not have protocols in place for all their PRN medicines to ensure people received medicines when they needed them. For example, one person had a protocol for Paracetamol but did not have one for their PRN medicine for their epilepsy. PRN protocols inform staff when the medicine should be given and what it is expected to do. Therefore, this is essential guidance for staff to manage the risk of this person's health condition with their emergency medicine. In some cases, the reasons the PRN medicines were given was noted but it was not recorded whether the medicines had any positive outcome. This is not in line with good practice guidelines for managing medicines in care homes. Care home providers should monitor and evaluate the effects of medicines and information on people's PRN medicines should include what the medication is expected to do.

People told us they had their medicines and knew why they took them. People had risk assessments in place for their medicines and people's support plans included pictures of their medicines and what they were for. People's medicines records included if they had any allergies, what medicines they took and potential side effects. Medicines Administration Records (MARs) were completed and stock control checks were done. MAR charts are a document to record when people received their medicines. Records confirmed medicines were received and administered correctly. Staff were trained in medicines administration and received competency checks. Additional training was given to staff where required around individual medicines procedures, for example staff had training to administer emergency epilepsy medicine. Audits had identified medicines errors and defined what action to take.

However, medicines were not always being stored safely and in line with the providers policy and best practice guidelines. Storage temperatures had been recorded as above 25 degrees for nine days during July and August 2018. Medicines were stored in a small room and the window did not open. The temperatures were taken between seven and nine o'clock in the morning and were likely to have been higher later in the day. One medicine was stored in a separate cupboard and the temperature of this was not monitored at all. The records did not indicate for staff what the temperature should be and there were no records of any action taken where the temperatures were too high. The providers policy is that this should have been reported if it was above 25 degrees. The providers systems did not therefore ensure that the medicines stored during that period were still effective for use as they had not taken any action to manage the impact of the hot summer weather.

The failure to ensure the proper and safe management of medicines was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Regulation 12.

At our last inspection, staff did not always have the guidance required to minimise harm to people. At this inspection, not all risks to people were assessed and therefore staff did not always have the guidance they needed to ensure people were supported to remain safe. Care plans contained risk assessments specific to health needs such as mobility, nutrition and pressure damage. For example, one person identified as at risk from pressure damage to their skin had a pressure relieving mattress, checks were in place to ensure the mattress was operated correctly and they were supported by a district nurse. However, there was no risk assessment for a person who presents with behaviour that challenges. This meant there was no guidance for staff on how to manage the risks to people and themselves. This is an area which needs improvement, risk assessments need to be in place for all people who may display behaviour that challenges. We have informed the provider of this concern.

Safeguarding and whistleblowing policies were in place and were in line with Local Authority safeguarding procedures. People told us they would speak to staff or the manager if they had any concerns. Staff had received training and were able to tell us what they would do in the event of a safeguarding concern. One staff said "It is about neglect and abuse. We're here to make sure nobody is taken advantage of. If I saw something I would try to diffuse the situation, then I would report it and would keep reporting it until something is done." Another staff member spoke confidently around their whistleblowing responsibilities.

Safeguarding concerns had not always been reported and acted on by the provider. An allegation of abuse had been made by a relative about an employee and was not reported onto their electronic incident records until a month later. There was no evidence that anything had been done to protect people. A senior manager told us the allegation was being investigated, however the other staff member told us no-one had spoken to them about it. We informed the senior manager of their responsibilities to safeguard people and notify the relevant authorities. Since the inspection the senior manager has provided evidence that they acted on our feedback. The allegation was referred to the local authority for consideration under their safeguarding guidance and reported to CQC on the day of our inspection.

The failure to ensure people are protected from abuse and improper treatment, that systems are operated effectively to investigate, immediately upon becoming aware of, any allegation of abuse; and that providers must act as soon as they are alerted to alleged abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were kept safe from environmental risks. Fire safety risks were managed. Weekly safety checks were completed for fire alarms, fire doors, fire extinguishers, emergency call points, smoke detectors and emergency lighting. There was a fire evacuation plan by the front door which had names of people and the support they needed during evacuation. All people had a personal emergency evacuation plan in place. Fire drills were completed every six months. PAT testing was completed in line with the providers policy and first aid kits were checked. The provider had managed the risk of legionella and monitoring checks for this had been recorded in line with their policy.

People told us there were enough staff. One relative told us they think they are understaffed and another relative told us "there is more than there used to be". Whilst the provider had robust systems in place to identify what staffing levels they needed, they struggled to cover the identified staffing hours required. This was due to difficulty with recruiting staff. A senior support worker told us that staffing levels were discussed at people's care reviews where a tool is used to calculate the hours needed to provide people's care. The service used agency staff and they booked these two weeks in advance. The staff have started working across both homes to help cover the shifts and the manager was on site and could cover for staff when they were short. One staff member told us "There is a staffing problem full stop but that's down to recruitment… Yesterday there was one person in house five and one in house four. An agency came in eventually, but was

half an hour late. (Name) needs two people to be hoisted. Sometimes we can't even get staff from agencies…Everyone got what they needed. You still have to give the same service but I didn't get a break for seven and a half hours." Senior staff described several initiatives the provider used to recruit more staff, such as the use of apprenticeships and a refer a friend scheme where staff were rewarded with vouchers if they referred someone.

The provider did not always learn from incidents and accidents. An on-line system was used for reporting accidents and incidents and staff have received training on how to use the system. A senior manager told us they received alerts from this which they then investigated and input their feedback into the system. A senior manager reported back at the team meetings on any incidents and near misses. They told us how this is also fed into national health and safety meetings, where patterns and trends were identified and lessons were learnt. Where incidents of behaviour that challenges had been reported they were not always acted on and therefore lessons were not always learnt when things went wrong. For example, one person had become physically aggressive towards another person but their support plan had not been reviewed to reflect any learning from the incident to prevent any further incidence.

Staff were trained and safe recruitment practices were carried out by the provider. All staff had been subject to criminal record checks before starting work. These checks were done by the Disclosure and Barring Service (DBS) and supported employers to make safer recruitment decisions and prevent unsuitable staff being employed. Staff files contained all the information required such as a photo and ID. Applicants were asked to complete a full employment history and gaps in employment history were explored. References were sought and followed up.

People were protected from the risk of infection and were cared for in a clean environment. Infection prevention and control policies and systems were in place. Staff were trained and understood how to prevent and control infection. We observed that staff followed procedures, for example wearing gloves and aprons. One staff member said, "We encourage people to wash their hands before they eat. If we are sick we can't come to work until we are better…We use red bags for soiled laundry, it gets washed at 60 degrees… We are observed all the time."

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 26 July 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people's needs were assessed and people's care designed to meet their needs and preferences. People were at risk of not receiving the care and support they needed as assessments were not taken at times of change, care plans were not kept up to date or they were contradictory, with a lack of guidance for staff. An action plan was submitted by the provider who implemented additional accessible support plans which detailed how to meet people's needs and choices.

At this inspection people told us that staff knew how to support them. People's care needs had been assessed, for example the staff had worked with other health professionals for one person with multiple health needs whose health had deteriorated quickly. They had reviewed their assessed needs, enabling an increase in the individual support hours provided. Another person had been referred to other health professionals as the service identified they may have dementia. Another person had a blue toilet seat to help them manage this activity with their dementia. Toilet seats in colours that contrast with the toilet and nearby surfaces can help make these more visible for a person with dementia and thus helping them to maintain their independence with using the toilet.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider was not always working within the principles of the MCA 2005. People had mental capacity assessments completed but these did not evidence what steps, if any, had been taken to support the person to make the decision; and there were no corresponding best interest decisions recorded where it had been decided that people did not have capacity. For example, for people who lacked the capacity to decide how to manage their medicines, there was no consideration of whether it was in their best interest that they are fully supported with their medicines administration. The provider could not therefore be assured that decisions had been taken in people's best interest and people were at risk of their rights not being protected. Records evidenced that people consented to their care where they had the capacity to, and communication profiles included the support people needed to make decisions. Although these had not been used to support the mental capacity assessments completed. DoLS applications had been made and one DoLS authorisation had been returned recently.

The failure to work within the principles of the MCA was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Regulation 11.

Staff told us they received supervision. One staff member said, "(Name) did mine (supervision) in July because we didn't have a manager at the time. We normally get them a few times a year unless we ask for it." Another staff member said, "I don't wait for supervision, I will talk to the manager whenever I want to." Staff received the training they needed to fulfil their role in general. There was a mixture of face to face and on-line training and there were systems in place to ensure staff stayed up to date with their training. One staff member said, "I have just finished the care certificate…it's a company who support people to progress". The care certificate is designed to evidence that care staff have the right skills, knowledge and behaviours to fulfil their role to a consistently high standard. However, staff did not always receive the training to ensure people's individual communication needs were met, for example staff were not trained to use makaton for one person who used this and had very little verbal communication. Although there was information on makaton signs in the persons care records, two staff told us they were not trained to use makaton. Makaton is a language programme using signs and symbols to help people to communicate. One staff said "It would be nice if we were trained in makaton, apparently its quite easy to use. We would be able to do 1:1 with (name) who doesn't talk to us verbally very well. We could find out an awful lot about (name) if we knew." When we met with people in the main lounge, this person was sitting in the lounge. Both staff and people told us in front of the person that they don't talk and they didn't tell us how to communicate with them. We did not observe any use of makaton with this person.

Agency staff also received the training and information they needed to fulfil their role. There was an 'introduction to our residents' folder for agency staff to provide the main information they needed to work with people. One of the agency staff had been working at the home for some months and told us they had completed several training courses to enable them to work with everyone. They said "I had an induction around the building … I completed a folder which had brief information about the residents. I was observed before I started to work with people by myself …I don't have supervision or attend team meetings but they inform me what is new. They treat me with respect. I did attend a best interest meeting when professionals came from the council for (name). I know them well so they invited me."

People and relatives told us they were happy with the food provided. One relative told us their loved one "gets to help draw up the menu". People were supported to cook their own meals in the kitchens. Staff told us that people were supported to menu plan and to go shopping. There was fresh fruit available in the dining rooms. People who had specialist needs around their diets had an eating and drinking assessment completed.

Staff worked together and with other agencies to deliver care. People were supported to access the health care they needed and there were records in place to support this, such as health action plans which included pictures and hospital passports. Hospital passports provided important information about the person in case they were admitted to hospital, including their likes and dislikes. Health appointment records were detailed and included outcomes, for example for one person who had visited the dentist, their records included details around the treatment they had for a filling.

The home had been adapted to meet people's needs, for example around their mobility. The manager informed us of plans to redecorate and how some people's bathrooms were being replaced. Consideration had been given as to how to make this as least disruptive as possible for people.

Requires Improvement

Is the service caring?

Our findings

People's views on whether staff were caring were mixed. One person told us "They don't talk to us very nicely" and another person said, "They boss you around". One person didn't want to say and another person said, "Everybody's caring". Relatives we spoke to believed staff were caring and that their loved ones were treated well. Staff knew the people they cared for well. We saw positive personal interactions between staff and people throughout the day. For example, staff using friendly banter in their conversations with people.

The provider considered people's individual protected characteristics under the Equality Act 2010. This means people were protected from unfair treatment in relation to identified personal characteristics: people's age, disability, race, religion, gender, sexual orientation and gender reassignment. The manager told us that people's equality, diversity and human rights (EDHR) were considered within their pre-screening assessment and that there was no-one currently with any cultural needs. There were some people that practiced a religion and they made sure that people with a disability had the equipment they needed to be able to go out. People's needs had also been considered under 'registering the right support'. People were part of and able to go out into the community like any ordinary citizen, for example to the GP or to the shops.

There was a person centred culture evidenced in the environment and in the way people were cared for. People's rooms were personal and reflected their interests. There were pictures or names on some people's bedroom doors if they chose to have them. The service offered people different spaces to relax in. For example, there were dining rooms, lounges and gardens. Some people had their own chairs or own spaces within communal areas. There was lots of art works on the walls which had been done by people.

People were supported to maintain contact with their families and all relatives we spoke with told us they were made to feel welcome and could visit when they wished. Two relatives told us they had shared their concerns with the provider around being better informed, for example when their loved one became unwell. Relatives were invited to annual care review meetings.

People were supported to use their local advocacy services and these services were promoted through leaflets on notice boards. Advocacy services offer trained professionals who support, enable and empower people to speak up. The operations manager gave us an example of when advocacy had been used when one person was considering leaving the home. This enabled the person to be supported independently with their decision about whether to move.

The manager was not aware of the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Providers of health and social care services are required to follow the standard to make sure that people have every opportunity to understand and be involved in their care plans and documents on an individual basis. However, accessible information had been provided to people in a way which met their individual needs. For example, the complaints procedure was available in picture form and peoples care plans included pictures and large fonts. People had communication passports which provided

information on their communication needs.

We recommend that the provider seeks advice and guidance from a reputable source on implementing AIS.

People were not always kept informed and involved in their day to day care. For example, one staff member told us "with meals we will check the freezer, will hand pictures of the meals out and let them choose what they want for the week. We put the picture up for the day and who chose it". However, these were not kept up to date on the notice board in the kitchens as the weekly menus displayed on notice boards in both houses were from the previous week and therefore people had not been informed of the menu for over 4 days. In one house one person told us they didn't know what they were having for dinner that night and in the other house, one person told us they were having "carbonara tonight". Records showed that people were involved in their reviews, along with their relatives and external health and social care professionals.

Staff respected and promoted people's needs for independence, privacy and dignity. People were encouraged to be as independent as possible for example, choosing their own clothes to wear and helping to prepare their own meals. People's care plans described how to meet these needs. People told us staff respected their privacy and dignity. Staff could tell us how to promote people's privacy and dignity by making sure bedroom doors were closed when providing personal care; knocking before entering people's bedrooms; explaining what they were doing and offering choice. One staff member said "Privacy is paramount. I knock on doors, ask permission. I ask if they want their hair washed or want to help with lunch or if they want the door closed when they go to the toilet. Do not take it for granted you can do anything you want to, it's their home. We're just guests…". Confidential information was kept secure and there was evidence that the provider was aware of data protection laws.

Requires Improvement

Is the service responsive?

Our findings

We observed an incident where a person had become unwell and the staff responded promptly to ensure they received urgent medical attention. However, people's care was not always responsive to their needs. Not all people who presented with behaviour that challenges had positive behaviour support plans. Therefore, they did not identify the signs, triggers and strategies staff can use to manage people's behaviour positively and in the least restrictive way. One person's care plan identified that the person wished to be supported to manage their behaviour that challenges with their friends and family but they did not detail what the behaviour was and how to support the person. This is not in line with the principles of person centred care. The failure to provide staff with written guidance on how to support this person responsively with their behaviour that challenges meant there was a potential risk of an inconsistent approach from the staff team to meet the person's needs.

People's care plans, where reviewed were person centred and included things which were important to the person, their likes and dislikes and their achievements. They detailed the support they needed on a routine basis but also any goals they had. For example, one person's care plans described the support the person needs to maintain their relationship with their friend who had moved away. Aside from people with behaviour that challenges, people's care was designed to meet their needs. Care plans included information for staff around people's individual needs. For example, how to support them with their dementia, epilepsy or mobility needs. One person who had needs around their mobility attended a falls group to help strengthen their leg which was run by the local learning disability team. Assistive technology was used to support people's care where appropriate. For example, one person with epilepsy had a monitor under their mattress to monitor if they had any seizures during the night. This enabled staff to ensure the person was safe and respond if support was needed.

People were supported to manage their finances and in some cases HF Trust were their appointees. There was finance policies and procedures in place and staff told us how monthly reconciliations and audits were completed by staff who were independent from the persons support in this area.

In line with 'registering the right support' people with learning disabilities were part of their communities, they used local facilities and accessed community health and leisure facilities. The homes had their own vehicles which enabled people to access their community. People were supported to take part in activities they liked. People told us they go shopping and to social clubs and the provider had two vehicles to enable people to access the community. Some people went to the day centre on-site. Another person went to a different day centre as they chose to continue to attend when they moved to Phillippines Close. Staff told us how one person had just returned from the Italian grand prix and how the person goes every year; and how two people had recently been supported to camp at a music festival for a weekend. Staff told us how they have been growing vegetables in the garden with people and had a recent tea party. One person had a pet cat, which all had agreed to have in the house. There had been a recent 75th birthday party in one house.

People told us they would talk to the manager if they had a complaint and relatives told us they believe their loved ones would be listened to. The complaints procedure was on display in the front foyer and there was a

complaints policy in place. A senior manager told us they kept a log of complaints and described how they have learnt to personalise complaints, for example asking people what their best outcome would be. One relative had complained they were not involved in the end of life support planning for their loved one. The manager had spoken to the person and agreed to carry out a review for this.

People had end of life person centred plans which detailed their wishes or recorded if they didn't know what they wanted. A funeral of a person who had died had been held at the home recently to enable people who live there to attend. We were told that people brought instruments and sang songs. The person was then buried afterwards next to their mum and dad.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 26 July 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate systems to assess, monitor and improve the quality of the services provided and failed to maintain accurate and complete records. People's needs were not always documented or records updated and the providers auditing systems had failed to identify the concerns around medication. The provider submitted an action plan to us in response. They had reviewed their auditing plans and the providers quality and improvement team had completed further audits.

At this inspection, we found that this breach had continued. People's care plans had not always been updated and reviewed. For example, one person's care plan read they liked to sign their own MAR sheets but this was not current practice. Staff were aware that many care plans were overdue for review and had started to work their way through these. Care records were not always completed adequately, for example fluid monitoring. These records did not include totalling the amount of fluid taken, and what action to take if the person did not have enough. Staff told us about incidents of behaviour that challenges which had not been reported, for example where one person had hit a staff member. The provider had failed to identify that these incidents had gone unreported and where incidents had been reported, people's care plans had not been reviewed as a result.

There was not a robust system in place to ensure clear records of medicines being disposed of. For example, a bottle of liquid medicine which had expired on the first of August 2018 had not been logged in the medications to be returned book. Records showed that the last gas safety check was December 2016 but the providers policy is to compete this annually. Service records did not include what action had been taken to identified health and safety risks of accidental scalding from hot water delivered above the recommended temperature range. Records showed that hot water temperatures for people's showers and the communal bath were above the recommended safe temperatures. The provider's policy is that this should have been reported. There was no information in the records that these had been reported and the monitoring form did not indicate what these temperatures should be. We informed the registered manager of this during our inspection who has since informed us that the boiler was faulty, was replaced at the end of August 2018; and people had one to one support with their personal care so staff would check the water temperature.

The provider did not demonstrate continuous learning and improvement. A senior staff member told us how an internal inspection was done last year with an action plan and how they report back to their senior managers on the progress made. They completed monthly service audits and quarterly inspections of health and safety standards. The last two health and safety inspections completed indicated there were concerns noted but did not offer any details. Registered manager monthly service audits and health and safety monthly audits had not been completed since March 2018 due to the absence of a registered manager. There was not a robust arrangement to ensure good day to day management until the new manager started. Provider audits had either failed to identify, had not acted on or failed to make all the required improvements. The provider had failed to complete all the actions they identified following our last inspection to meet this regulation. Senior staff could describe to us well the duty of candour but this was not

well evidenced as incidents were not always reported internally and externally, safeguarding's were not always made and therefore people and where relevant their relatives were not always informed of these incidents.

The failure to operate effective systems to assess, monitor and improve the quality and safety of the services provided; and the failure to maintain accurate and complete records was a continued breach of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014, of Regulation 17.

The provider had not always informed CQC of certain changes and important events that happened in the service. These are referred to as Statutory Notifications. This enables us to check that appropriate action had been taken. In this instance they had not informed us of any allegations of abuse they had received and safeguarded. We informed the managers of this at our inspection.

The failure to notify CQC of allegations of abuse is a breach of Regulation 18, Care Quality Commission (Registration) Regulations 2009.

People told us they liked the manager. Relatives told us they hadn't met the new manager yet. Staff records showed that staff had not received regular face to face supervision in line with their policy. The managers were aware of this and evidenced how they have planned for all staff to receive face to face supervision during October and November. Staff did not always feel supported by the manager. One staff member described a culture where the manager doesn't get involved and said "I think we work well as a team but everyone needs to be shown. Managers should shadow so they know what to do. You need to work on the floor to know people's needs. What we would like is for (manager) to get more involved with us. If we are short staffed I'd like (manager) to ask if they can help". Another staff member said "The culture is transparent here. We're allowed to say what we want. I have had so much support. Everyone comes to work to look after the residents. We have 'the fusion model' which is about communication, person centred planning, it's about community…Leadership is visible, (name) is around."

Staff and managers were encouraged to complete further training and the operations manager described how they see themselves as a learning organisation. There was a development pathway for staff where they could start as a support worker and potentially become a director. Staff told us they were not having team meetings since the last registered manager left in April 2018 and then they were only held with the people on shift at the time. One staff member described how they need a team meeting to raise issues and to meet with their colleagues as they don't often see them. Another staff member told us, "I asked for a staff in and out book for the house, like when people go to the day centre. It means you don't know who is in the house if the alarm goes off. Plus, we have staff who go off to do their own thing for a while…I asked (manager) but I don't know if they heard me, it was about a week ago." This feedback was passed onto the provider for actioning.

Staff were invited to 'have their say' through on-line feedback and surveys were in the process of being sent out to health professionals. Similarly, a family and friend's questionnaire had been completed and whilst the collated feedback showed 78% of surveys were returned, there was no action plan, learning from the results or any evidence that anything had changed because of the feedback. For example, 28 people replied 'sometimes' when asked if they think the service is well managed; and 28 people replied 'sometimes' when asked if they would say communication between them and staff is good. This was the middle of the rating scale which ranged from 'yes always' to 'never' yet there was no evidence what the provider had done to act on this feedback. People and their relatives were not always involved in the service. There used to be monthly resident meetings but there had not been any recently. One person was involved with helping HF Trust with staff recruitment. Family forum meetings were held twice a year and this was confirmed by one

relative we spoke with.

The provider worked closely with their local authority and a senior manager described how they have built up positive relationships by having regular meetings. They had built up a partnership with a local school to promote a positive image of working within the care industry and to support the schools fundraising.

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 judgments. The provider had displayed their ratings in the front foyer area and on their website.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to work within the principles of the Mental Capacity Act 2005 Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines Regulation 12 (1) (2) (g)

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 provider had failed to ensure people were protected from abuse and improper treatment, that systems were operated effectively to investigate, immediately upon becoming aware of, any allegation of abuse; and that providers must take action as soon as they are alerted to alleged abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and

safety of the services provided; and failed to maintain accurate and complete records
Regulation 17 (2)(a)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of allegations of abuse. Regulation 18

The enforcement action we took:

Fixed Penalty Notice.