HF Trust Limited

HF Trust - No 3 & 4a Milton Heights

Inspection report

Potash Lane
Milton Heights
Abingdon
Oxfordshire
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Tel: 01235827615

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27 February 2019
06 March 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: HF Trust – No 3 & 4a Milton Heights is a residential care home that was providing personal care to five people with a learning disability at the time of the inspection.

Rating at last inspection:

At the last inspection the service was rated Requires Improvement (published 15 March 2018). We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, responsive and well led to at least Good. At this inspection, the service remained Requires Improvement. This is the second consecutive time the service has been rated Requires Improvement.

Why we inspected:

This was a planned inspection based on previous rating.

People's experience of using this service:

• The service was not consistently well led. The registered manager carried out quality assurance checks however, they had not identified the areas of concern found during this inspection.
• People did not always receive safe care and support. Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service.
• People were at risk of having their safety compromised. This was because safety checks such as fire drills were not taking place to ensure staff knew what to do in the event of fire.
• Medicines were not always managed safely.
• We found where people lacked capacity and were being deprived of their human rights that the principles of the Mental Capacity Act were not always followed. We made a recommendation that the provider refers to current guidance.
• People's records had information on leisure and hobbies and how they were to be supported to take part in their interests and activities. However, feedback and records did not reflect these goals as being met.
• There were enough staff with the appropriate training and support to give people the care and support they needed.
• Recruitment arrangements were robust to ensure the right staff were recruited.
• People were protected by the provider's prevention and control of infection procedures.
• People were supported to access health care when needed and sufficient food and drink was available to people throughout the day.
• We observed and received feedback that people were supported by kind and caring staff.
• The service had been developed and was designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance.

Enforcement:

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure the rating of the service improves to at least Good. We will re-inspect the service within our published timescales to see what improvements have been made. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

HF Trust - No 3 & 4a Milton Heights

Detailed findings

Background to this inspection

The inspection:

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

Inspection team: One inspector.

Service and service type:

HF Trust – No 3 and 4a Milton Heights is a 'care home' registered to provide support to a maximum of five people. People in care homes receive accommodation and nursing or personal care as 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 service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection took place on 27 February and 6 March 2019. The first day of the inspection was unannounced.

What we did:

Before the inspection the provider completed a Provider Information Return (PIR). A PIR is key information that providers are required to send us about their service, what they do well, and improvements they plan to

make. This information helps support our inspections. We also looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

Not all people living at the service were able to fully share with us their experience of living at the home. Therefore, we sought the views of people who knew them well.

We looked at two people's care and medicines records. We also reviewed four staff recruitment files including staff induction, supervision and training records. We reviewed a range of records relating to the management of the home including records of accidents, incidents and complaints, audits, surveys and quality assurance reports, checks to ensure a safe environment and a variety of policies and procedures developed and implemented by the provider.

We spoke with the registered manager, operational development manager and three members of care staff. We also spoke briefly with one person in the service. Following the inspection, we contacted three relatives and heard back from two. We contacted three health and social care professionals and commissioners involved with the home and received feedback from one.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Following the last inspection in January 2018, we asked the provider to complete an action plan to show what they would do and by when to improve the key question Safe to at least Good. This was in respect of making improvements to identify, monitor and review risks to people to ensure their safety. We also asked action to take place to ensure people's medicines were safely managed. We asked that mandatory checks on the home's environments be carried out. At this inspection, we found not all appropriate action had been taken as requested.

Assessing risk, safety monitoring and management

● Not all people had assessments of risk associated with their care and support. For example, we saw a person with a health condition had support plans in areas such as personal care and leisure and hobbies. There was no mention of any risks associated with their health condition on their support plans. At the bottom of the support plan there was a section entitled 'Risks - Are there any risks which need managing within this support?' It was stated: 'No records for this section'. We were told that risk assessments were kept separately to support plans but there was no signposting so all staff were made aware of associated risks. Therefore, not all had been done to protect people from potential harm during their care and support. Following the inspection, we were sent evidence that relevant support plans had been updated to reflect the risks.
● The service's approach to assessing and managing environmental and equipment-related risks was inconsistent. We found no record of any fire drills since the last inspection in January 2018. A staff member informed us that they did sleep in shifts twice a week but had never completed a fire drill. Following the inspection, we received notification that these had taken place but had been recorded elsewhere and we received no evidence of these. The registered manager informed us that two fire drills had been carried out since our inspection on the 27th February 2019. We looked at other environmental checks and saw that weekly checks were taking place on smoke detectors; fire doors and emergency lighting. The forms asked for the date and time of check to be recorded but these details had not been recorded and were just marked with a tick. The lack of required monitoring in respect of monitoring safe practice around fire safety meant the provider could not be confident that people would be safe in the event of a fire.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care and support. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Using medicines safely

● The registered manager was not clear about their responsibilities and role in relation to 'as and when required' (PRN) medicines. The provider's policy had not been followed in relation to non-prescribed medicines. This stated that PRN medicines could only be administered 'Where the GP has previously agreed the use of these remedies for the individual, having checked for contraindication and allergies and there is written evidence for this agreement' or 'Where the member of staff intending to administer the remedy has checked with a pharmacist that there are no contraindications to conditions or medications already being taken and that this advice has been recorded. There was no record of this in two people's records which meant that there was no evidence that purchased medicines had been checked for potential interactions with prescribed medicines with an appropriate healthcare professional before use.
● Individual guidelines for PRN medicines had not always been followed. For example, one person's medicines had not been administered as instructed in line with medical guidance which could have increased the person's risk of harm.
● We saw in a person's records that a letter dated October 2018 had been received from their GP about seeking advice from another medical professional regarding continuing use of an over the counter medicine. We asked the registered manager about this who confirmed that this advice had not been sought. Following the inspection, we received evidence that this advice had been sought and agreed for all people in the service using over the counter medicines.

We were not assured that all reasonable steps had been taken to ensure the proper and safe management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Learning lessons when things go wrong

● The provider's systems and processes that were in place to identify any learning following incidents had not been used consistently or effectively. For example, we reviewed an incident which had been investigated. The investigation had not considered if changes needed to be made to prevent future incidents.
● The registered manager understood their responsibility to report all concerns in accordance with the provider's policy and procedures.

Systems and processes to safeguard people from the risk of abuse

● Staff understood their role in protecting people from abuse. All staff had received training in safeguarding adults. The registered manager had a good knowledge of safeguarding and had raised issues with the Local Authority when concerns had been identified.
● Staff told us they were encouraged to discuss any concerns and were supported to do so by the registered manager.
● One person's relative told us, "No reason to feel they [person] are not safe".

Staffing and recruitment

● We looked at how the provider was recruiting new staff members. A range of pre-employment checks were being completed prior to new staff members starting work. This included identity, reference and Disclosure and Barring Service (DBS) checks. Employers use DBS checks to review a potential employee's criminal history to ensure they are appropriate for employment.
● There were enough staff with the appropriate training and support to give people the care and support they needed. During our visit to the home we saw that staff were meeting people's support needs.

Preventing and controlling infection

● Staff had received training in preventing and controlling the spread of infection and had access to relevant guidance and information.
● Staff followed effective infection prevention and control practice. Staff members confirmed that they had appropriate personal protection equipment like gloves and aprons available when supporting people.
● At this inspection the home appeared to be clean and tidy.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

● We saw people had documentation about consent which had been given by unauthorised persons. There was no evidence of a capacity assessment in respect of the decision and no record of a best interest decision. For example, consent has been agreed for service user's photographs to be used on their behalf by relatives.

We recommend that the provider refers to current guidance in respect of how consent should be sought in a way that meets legal requirements.

● People were supported by staff that knew the principles of The Mental Capacity Act 2005 and people's rights to make their own decisions were respected. One member of staff told us, "I always provide choice such as clothing and food. However, I also encourage consideration if the choice of clothing may not be suitable for the weather conditions".
● Where people were being deprived of their liberty appropriate applications had been submitted to the local authority.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Assessments were personalised containing information and guidance specific to each person's needs and wishes.
● The service worked closely with other health and social care professionals to complete pre-assessments; which helped to ensure they were able to provide the right support and improve the quality of people's lives.
● Staff told us they received training and regular updates on changes to guidance or the law. This ensured they were providing best practice and effective care and support to people.

Staff support: induction, training, skills and experience

● Staff were knowledgeable about how to support people effectively and felt they received the appropriate training to support people's needs. A member of staff told us, "We have lots of training, either e-learning or face to face. I was observed when I administered medicines and have yearly updates".
● New staff completed an induction programme including shadowing staff delivering care, face to face and e-learning training and competency checks, before directly working with people. A member of staff said, "I was introduced to people and colleagues when I started. I read information on people and shadowed other staff for two to three weeks".
● Staff received regular supervision with their line manager or the registered manager. Staff told us and records showed supervision supported staff in the continuing development of their skills, competence and knowledge. A member of staff said, "I find supervisions helpful".

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

● People were encouraged and supported to participate in the choice and preparation of their meals as much as possible.
● Staff were trained in food health and hygiene and promoted a balanced diet and encouraged people to drink fluids.
● Where necessary, people had been referred to dietitians to improve their health through their diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The service had effective links with health and social care services and advice had been sought from healthcare professionals where relevant, for example, epilepsy support.
● People were supported to attend health related appointments, such as dentists and opticians.

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

● The home had been decorated since the last inspection. We saw that people's bedrooms reflected their individual preferences in how they were decorated and contained items of importance and interest to them. However, the lounge was still quite sparsely decorated and did not have a homely feel to it.
● Personalised technology helped people to maintain their independence and increase their safety. For example, bedroom finger print door locks, automatic curtains opening and closing, door sensors and a seizure monitor under a person's mattress.

Good

Is the service caring?

Our findings

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were motivated to provide care which was personal, kind and compassionate. Staff had developed caring and respectful relationships with people. A relative told us, "The staff always appear friendly and [person] seems to like all of them".
- The diverse needs of people using the service were met. This included individual needs that related to disability and gender. Staff received training regarding equality, diversity and human rights.

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

- Care plans were completed with people to ensure they reflected people's wishes.
- The PIR stated that most of the staff had worked in the service for a number of years and had developed good relationships with the people they supported. Examples included, supporting people going into hospital, and staff ensuring that people were comfortable and not distressed in any way.
- People were supported to keep in touch with their families. For example, one person was taken some distance on a regular basis by staff to maintain contact with their relative.
- The service applied the principles and values of Registering the Right Support and other best practice guidance. These principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.
- People were involved in regular reviews of their needs to ensure the support and care they received was meeting their preferences and decisions. People's representatives and relatives were also involved, as appropriate, in line with information sharing and consent arrangements. A relative confirmed they were appropriately involved in reviews about their loved one's care and support.

Respecting and promoting people's privacy, dignity and independence

- Staff supported people to be as independent as they could be for themselves. A member of staff told us, "We always try to promote independence where possible".
- People were treated with kindness and respect. We observed staff talking to people in a respectful way and showing genuine warmth.
- Staff respected people's privacy and dignity. A member of staff told us, "We always knock on doors and help people preserve their dignity during personal care".
- Personal records about people were stored securely and only accessed by staff on a need to know basis. Staff understood their responsibilities for keeping personal information about people confidential.

Requires Improvement

Is the service responsive?

Our findings

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

RI: People's needs were not always met. Regulations may or may not have been met.

Following the last inspection in January 2018, we rated the key question Responsive as Requires Improvement. This was in respect of people's support plans not reflecting up to date information. At this inspection we found further improvements were needed to show how people's care had been delivered to meet their preferences.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● We were informed that people's individual goals were recorded on Support Planning Assessment and Records (SPARS), and were broken down into steps, progress monitored and recorded against. However, people's records contained minimal evidence to show how individualised care and people's preferences had been met. For example, a person's goal was described in their support plan but there was little evidence about how this was being aimed for, or achieved. After the inspection we received feedback from the registered manager who said that after discussions with staff, in respect to the person's behaviours, that it had been decided in the person's 'best interest' that the goal would be taken off their support plan. There was inconsistent recording about what people were doing on a day to day or weekly basis. This meant it was not evident that people were being provided with the opportunities to engage in activities or interests they had expressed an interest in.
● We asked relatives for feedback and one person said, "I don't think [person] has the trips out they used to have. I have asked if [person] could perhaps have some social interaction with [person] but it doesn't seem to happen and most weekends if not with us, seem to spend a lot of time in their room, or doing housework".
● A member of staff said they felt one person needed more encouragement to engage in activities and was not sure all was done that could be, to enable this to happen.

We were not assured that all reasonable steps had been taken to ensure that records were accurate, complete and contemporaneous in relation to the care and support provided. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

● We saw that people were accessing social activities during the inspection including going bowling. The registered manager said people were meaningfully engaged to avoid boredom and isolation but there was limited evidence about what people were doing.
● Providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard (AIS). The standard aims to make sure that people are given information in a way they can understand to enable them to communicate effectively. Information was available in ways to support people's individual communication needs. Information was provided to people in a format that was

accessible to them, for example, information in easy read formats.

Improving care quality in response to complaints or concerns

● Relatives were aware of the complaints procedure, however, they said they had no reason to complain. Staff were aware of their responsibilities in responding to, and reporting any concerns raised.
● Records showed complaints had been taken seriously and responded to with the outcome of appropriate action.

End of life care and support

● We saw evidence that the service had collected and recorded information in people's records to reflect their preferences in the event of their death. This ensured that people's views could be considered and acted upon in the future.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Following the last inspection in January 2018, we rated this area as 'requires improvement'. We asked the provider to complete an action plan to show what they would do and by when to improve this key question to at least Good at the next inspection. At this inspection we found ongoing concerns in relation to the quality assurance systems and governance of the service. There were repeated breaches of the regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager and provider had not operated systems effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. There were failings in areas which should have been addressed through the operation of robust systems of governance, audit and monitoring. For example, poor quality of records including risk assessments, safety of medicines and environmental risks.
- The registered manager and provider had not ensured records reflected a complete and contemporaneous account of how people's care, treatment and support had been provided.
- The registered manager had not consistently applied quality assurance processes consistently, and therefore, required improvements had not always been identified. The action plan from the last inspection stated all actions had been completed but we found evidence to demonstrate they had not been. For example, the action plan stated that, 'The weekly environmental safety checks will be carried out by the registered manager and the senior support workers. If they are designated to carry out the check and are unable to do so they must ensure that another member of staff carries out the check within 24 hours. [Registered manager] will ensure that there is no break in the carrying out and recording of these checks and that any actions required are completed in a timely manner. We found these checks had not been recorded as stated.
- The registered manager and provider had been reactive to findings from our previous inspection, rather than proactive in identifying areas that needed improving. This meant it was not assured that the measures in place were robust enough to ensure ongoing monitoring and actions taken where identified. This meant that not all required improvements had been made to ensure the service was compliant with all regulations.
- The above issues were identified during the inspection but had either not been identified or addressed by the registered manager and provider. Therefore, compliance had not been achieved to improve the monitoring of the quality and safety of the service provided so that it could continually improve.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● From our observations and speaking with staff and the registered manager it was clear that there was a positive culture in the service with the values of person centred care.
● Staff felt supported by the registered manager and said there was good team work and staff morale. One staff member said, "We work well together. Everyone gets along. Communication has always been good between us".
● The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager understood their responsibilities.

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

● People had opportunities to attend meetings, complete surveys or raise any comments during key worker sessions.
● At the last inspection, we had feedback from relatives that communication could be improved. The action plan had stated that the registered manager would make contact with relatives to ask how communication could be improved. We asked the registered manager and they said that communication with families had improved. Following the inspection, we asked relatives for feedback and had a mixed response. One relative said, "I am still in the position of never getting any feedback. Having an update with an email, text or phone call would help us to understand why [person] can sometimes present as unhappy and why they are upset". Another relative said, "I get a call from staff every week to update me".
● Staff felt able to express their views and could contact the management for advice at any time.
● Staff felt supported by the management team.
● The provider sent out annual surveys to all people and their relatives across the organisation to gain their feedback.

Working in partnership with others

● The service worked with a number of external parties, including local health and social professionals. We contacted those we were given information for and heard back from a commissioner with feedback of their visit to the service shortly after the last inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all reasonable steps were taken to reduce risks associated with people's care and support. Not all reasonable steps were taken to ensure the proper and safe management of medicines.

The enforcement action we took:

A warning notice was issued asking what would be done to improve people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient and inadequate systems in place to monitor and improve the quality of the service.

The enforcement action we took:

A warning notice was issued asking what action would take place to improve the governance of the service.