HF Trust Limited

HF Trust - Milton Heights

Inspection report

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

Summary of findings

Overall summary

This inspection took place on the 6 June 2017 and was an unannounced inspection. We also visited on 15 June 2017 to complete the inspection.

HF Trust Milton Heights is registered to provide accommodation and personal care for up to 33 people with learning disabilities. At the time of the inspection 25 people were being supported across six houses on the same site.

There were two registered managers in post. One registered manager was responsible for one of the premises and the other registered manager had responsibility for the five other premises. A registered manager is a person who has registered with the Care Quality Commission 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.

People's environment needed improvement. We found the houses were in need of refurbishment and redecorating to ensure they were appropriate and suitable for the current needs of the individuals living there.

In one of the houses, medicines were not always stored at the advised temperatures. We made a recommendation that advice is sought in respect of this. People had received their medicines as prescribed.

The service had systems in place to assess the quality of the support provided in the home. However, where improvements were needed these had not been acted upon by the provider in a timely manner to ensure that people were protected against the risks of unsafe or inappropriate environment. Other risks had been identified and recorded and action had been taken to reduce the risks.

Feedback from two professionals we contacted spoke of communication not always being as effective as it could be.

All staff spoke positively about the support they received from the registered managers. Staff told us they were approachable and supportive. The service worked with other professionals to ensure people in the service received the appropriate support associated with their health and wellbeing.

People told us they felt safe. Staff had received regular training to make sure they maintained their knowledge in relation to recognising and reporting safety concerns. Staff were aware of people's needs and followed guidance to keep them safe.

People were supported by staff that had the knowledge and skills to effectively care for them. Staff had received the training and support they required to ensure people received good care. The registered

manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA) which governs decision-making on behalf of adults who may not be able to make particular decisions themselves. People's capacity to make decisions was regularly assessed.

People had a choice about the food and drink they wanted. People were supported to plan meals, shop and cook if they were able. People we spoke with told us they enjoyed the food and had choices about what they ate.

People spoke highly of the care they received. Staff understood the needs of people and provided care with kindness and compassion. Staff spent time with people and treated them with dignity and respect.

People's care was planned ensuring that people were treated as individuals. People had been involved in developing their support plans and reviewing these. People were encouraged to be involved in activities and to take part in activities, such as hobbies and social events to ensure they did not become bored or socially isolated.

People in the service knew the registered managers and spoke to them openly and with confidence.

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.

The premises were not of a standard suitable to provide people with an environment that was safe and suitable for its purpose.

Medicines were not always stored at the correct temperature.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people had been assessed so they could be managed safely.

People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines.

Is the service effective?

Good

The service was effective.

Staff had the training, skills and support to care for people. People spoke positively of the support they received.

People enjoyed the food provided and had sufficient amounts to eat and drink. People received support with eating and drinking where needed.

The service worked with health professionals to ensure people's physical and mental health needs were maintained.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People's preferences regarding their daily care and support were respected.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was responsive.

People's support and care was individualised to ensure they were able to live their life as they chose.

Activities had been arranged to meet people's needs and to reflect their preferences. Community links were developed and maintained.

People were confident they would be listened to and action taken.

Meetings were conducted with people to discuss changes in their homes and to seek their feedback and suggestions were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not ensured that the quality assurance audits had been acted upon to improve the premises.

Communication with external stakeholders needed improving.

People and staff spoke highly of the registered managers.

Regular audits were carried out to monitor the quality of care. Learning from these audits was used to make improvements.

There was a whistle blowing policy in place that was available to staff around the home. Staff knew how to raise concerns.

Management and staff had a desire to deliver high quality care.

HF Trust - Milton Heights

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 checked 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.

This inspection took place on 6 June 2017 and was unannounced. The inspection was carried out by one inspector. We undertook a further announced visit on 15 June 2017 to complete the inspection.

We spoke with five people to seek their views. We also spoke with the operational manager, the regional manager, two registered managers, one senior care staff and four care staff. We also received feedback from two professionals. We looked at a sample of records, including four people's care records, medicine administration records (MAR). We also looked at a range of records relating to the management of the home and four staff files, including recruitment and training records.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The form was completed and returned so we were able to take the information into account when we planned our inspection. We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in February 2015 we found, and staff told us, that the environment was not always suitable to meet people's increasing needs. We were informed by the registered manager that plans were in place to build new and alternative forms of accommodation to better suit people's needs. People had been consulted and were looking forward to the move. Two years on, at this inspection, we found that five people had moved to new accommodation, however, others were still living at the premises. More suitable accommodation was planned but had not yet been provided.

We observed the living environments were in need of many improvements. One of the houses had an offensive odour from a toilet that spread throughout the house. We were told that regular cleaning takes place. The state of decoration in some of the houses were poor. One house needed redecorating; it had holes in the walls where things had been removed and was in need of painting throughout. We saw this had been noted in audits for the previous five months but did not appear to have been actioned. The bathroom had paint peeling off the side of the bath panel and fixture and fittings were stained. A person had to move bedrooms due to the growth of mould on the windows. We saw this had been reported in the health and safety checks in February and March 2017. This also stated that the floor was 'lifting' outside the downstairs toilet.

We saw records that staff had reported the above issues, but at the time of the inspection there appeared to be little progress in the decoration being improved. Staff worked hard to ensure the premises were as clean as possible, but due to the age of the properties and the amount of renovation needed, this proved difficult and time consuming.

Premises should reflect the needs of the people in them but we found them not all entirely suitable for their intended purpose. Providers must ensure they meet the requirements of relevant legislation to ensure premises and equipment are properly used and maintained. For example, the Equality Act 2010 states physical features that disadvantage a disabled person should be removed, altered, or a way of avoiding it provided. Guidance by the Health and Safety Executive, Health and safety in care homes (June 2014), state changes in floor surface, for example, stepping from carpet to a smooth floor or vice versa, can cause stumbles and slips, especially for people with impaired vision or mobility. We saw in one house that smooth flooring had a carpeted area which was not securely fixed down to avoid a trip hazard. The kitchen in this house also had flooring that was coming away from the walls which would be an infection risk. We did not see evidence that these had been identified and action taken to improve the areas of concern found. We were not informed of any timescales of potential moves to more suitable accommodation to meet peoples' needs. The provider sent us information that evidenced that they were developing plans for this.

These concerns were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had lived in the premises for 30 years. As time has progressed and people had aged, physical needs, such as mobility had decreased and therefore risk of falls had increased. Some improvements had

been implemented. For example, installing a lift in one of the houses, putting in rails and adapting the bathroom in two of the houses. This meant that some peoples' needs were met and in one house this had enabled a person to remain in their home until the end of their life.

Medicines were stored securely. However, in one house we noted that the temperature of the room where medicines were stored had exceeded the recommended temperature of 25c and below. The temperatures had varied between 24.8 and 28.1 degrees for the past five months. The registered manager checked with the pharmacy on the day of the inspection about the impact of this on the medicines. However, a full review of the effect on each medication stored in the area had not taken place to ensure the medicines remained effective at the exceeded storage temperatures.

We recommend the provider considers seeking further advice around the temperature management of the medicines storage area to ensure medicines remain safe and effective for the people.

People received their medicines as prescribed and records of these were accurate. Medicines were managed consistently and safely by staff that had received relevant training. Staff underwent yearly checks to evidence their on-going competence. There were 'as required' (PRN) protocols for all prescribed PRN medicines that gave guidance to staff how to assess if a person needed these medicines. For example, signs that a person may be in pain.

People had been assessed to see if they could safely manage their own medication. We saw assistive technology was used to enable this to happen safely. We saw two people's records who managed their own medication. A device which contained medicines had an alarm which sounded when it was the correct time to take the medicines. One person showed us this aid and explained how it worked. They said, "Staff will also check, just in case, but I don't forget".

Staff we spoke with could clearly explain how they would recognise and report abuse. Staff told us, and training records confirmed that staff received regular training to make sure they were able to identify abuse. They told us they would report concerns immediately to the registered manager or senior person on duty. They were also aware they could report externally if needed. Records confirmed the service notified the appropriate authorities with any concerns. There was information about safeguarding procedures available to staff.

People had risk assessments in place which identified any risks due to their specific health and support needs, such as epilepsy, nutrition and falls. These assessments included information for staff to follow to minimise the chance of harm occurring. For example, a person at risk of falls used a walker to reduce the likelihood of falls and also wore a sensor to alert staff if they fell. At the time of the inspection, we saw some people had pendant alarms to alert staff of falls. Another person's records provided information about their epilepsy and how to reduce risks. This included using a bed monitor, taking regular medication and guidance on seating in vehicles to allow the person to be seen in case they had a seizure. We saw this guidance was regularly reviewed.

Restrictions were minimised so people felt safe but also had as much freedom as possible. For example, a person who accessed the community independently, liked to talk to females. The service worked with the person to help them understand how actions may be perceived, and offered advice about places to avoid and how to conduct themselves when out to avoid any misunderstandings. Risk assessments were completed on a computerised system which allowed them to be monitored by managers and notify relevant staff when they were due for review.

Each house had risk assessments in place to monitor and reduce the risks of fire and household cleaning fluids. There were lone worker risk assessments in place to protect staff. Staff had received training on infection control.

The registered manager told us recruitment was an on-going process and agency staff were used to ensure staffing levels were maintained. Agency staff use was managed with agreed agencies to ensure any staff had the skills and experience to meet the needs of individuals. People felt there were enough staff to keep them safe and could always find staff when they needed them. One person said, "Of course they are available. We know where to find them and they always help." Staff told us there were enough staff to meet people's needs. We saw there was a 24 hour on call facility should staff require support out of hours.

The provider followed safe recruitment processes. Staff files contained the required pre-employment checks. This included references, and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Processes were in place to check the safety of equipment such as fire equipment, fire alarms, gas and electrical appliances and water safety and temperatures. We viewed the records and found that all checks had been completed as per provider's policy. For example, fire drills had taken place and evacuation drills. People had personal emergency evacuation plans (PEEPS) in place to protect people from untoward events. These plans were kept easily accessible to staff in the event of an emergency. A disaster plan had been reviewed in January 2017. This plan contained all actions necessary should the service experience an event that may have an effect on the service, such as fire or flooding.

Good

Is the service effective?

Our findings

Staff told us they received an induction and completed training when they started working at the service. Induction training included fire, moving and handling, infection control and dementia care. We saw that staff had received specialist accredited training in areas such as epilepsy.

Staff told us, and records confirmed they had support from their managers and met to discuss their roles and responsibilities. Records showed staff had access to development opportunities. Staff had received all training necessary to ensure they carried out their roles effectively. One staff member said, "The training is brilliant. All the areas I need to know about are covered." Other training included risk management, principles of good recording, professional boundaries and the Mental Capacity Act 2005 (MCA). We spoke with a senior staff member who told us about a new staff member who had recently joined. They were shadowing shifts with other staff and undertaking the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. We spoke with a member of staff who said the induction was, "Really good. I was able to shadow a member of staff till I felt confident to work alone." A professional told us, "The staff appear well trained and flexible in their approach. I have worked with a variety of staff from the service who have all been adaptable to guidelines recommended and appear to manage these with ease. For example, moving and handling and communication approaches have been implemented without further need for training."

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.

The registered managers and staff were knowledgeable about how to ensure the rights of people who lacked capacity were protected. Care records showed the principles of the Mental Capacity Act 2005 code of practice had been followed when assessing an individual's ability to make a specific decision. We observed and heard staff asking people's consent before providing support. Where a person potentially lacked capacity, staff were trained to follow the best interest process. The provider had developed a 'mental capacity' and 'best interest' checklist to record findings and decisions. We saw that where people lacked capacity, assessments were specific to each decision and best interest decisions were recorded in their files. For example, we saw that a person could consent and make decisions about things that were familiar to them such as what to eat, what to wear, where they wanted to go. However, it stated that they may struggle with new experiences or decisions such as receiving health care for a condition to keep them safe. It explained that these may need to be discussed at a best interest meeting.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that DoLS authorisations were in place for some people. We saw applications had been made where appropriate to the relevant local authorities.

People were supported to plan their menus and do the shopping for the meals. People told us they had a choice in what food they had. One person said, "I cook in the kitchen and staff help me." We saw a folder containing pictures of meals to assist people who could not verbally choose their meals. This meant they were given an opportunity to state their preferences and choices. Risks in respect of eating and drinking had been assessed by a screening form to see if there were risks such as chewing, choking or coughing when eating or drinking. If so, relevant referrals had been made to provide guidance to staff.

People were supported in their health needs by having access to health professionals such as GP's, dentists and opticians. Each person was offered a Health Action Plan, annual health check and an End of Life plan. We saw referrals had been made where needed and hospital appointments to check up on the management of their epilepsy. Assessments and referrals were all recorded in people's support plans. These included to Speech and Language Therapists (SALT) and neurology specialists.

Staff had been vigilant and acted quickly where concerns were noted. For example, staff had noticed a person with a concerning symptom. Immediate medical assistance was sought and investigations found a serious condition. The person was supported throughout the treatment by staff to assure the person and support them at a difficult time.

Where people had needed medical procedures or treatments that they may find difficult to understand, such as having a CT scan, the service accessed easy read information. They also prepared the person by arranging visits to the hospital to help the person prepare and cope with having the scan.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. Staff had developed trusting relationships and understood and respected confidentiality. People told us they were happy and felt cared for by all staff in the service. Comments included; "I'm well looked after. Staff are lovely, kind and helpful." A professional commented, "I have found all staff to be positive even when their resources are stretched. They appear to care and have a detailed knowledge of all the clients they support. Staff from all levels have always made time to listen and respond to the health teams."

We observed people were treated in a caring and kind way. On the second day of the inspection, people were helping to assemble a swing seat for the gardens. There was laughter and appropriate teasing towards staff. People were in and out of their houses and were clearly enjoying the afternoon and interacting with staff. Staff were friendly, polite and respectful when providing support to people.

Staff were knowledgeable about the care people required and the things that were important to them in their lives. A staff member told us about a person they supported. We saw that this reflected all the information we had seen in the person's support plan. The staff member said they loved their job and said the best thing was, "People being able to do the things that they love to do."

How a person communicated was documented in order to explain how that person expressed their wishes and choices. One person's records contained information stating the person had a good sense of humour and was good at creating a rapport with staff and others. It went on to say they understood sign language. Guidance advised that the person was likely to say a certain phrase if they did not understand something which meant staff needed to rephrase to ensure they understood.

Referrals were made to a speech and language therapist to further assist communication. We saw individual communication passports, Makaton and communication aids were used. Feedback had been received in the family questionnaires about the improvement they had seen in their family member's communication and confidence as a result of the support they were getting.

Independence had been encouraged through a number of ways including the use of personalised technology. For example, hot water dispensers so people could make their own drinks. People told us they were encouraged to be as independent as possible. One person said they needed help with the bath and putting cream on their back but said they were independent with all other areas and this was respected by staff. Care records contained information such as. '[Name] can wash independently but will ask for support to wash back and hair' and '[Name] can make light food and drinks with staff support. Needs support to understand sell by dates on food.' There was a section in the support plan about how a person wished to make decisions on areas of their life. For example we saw in one person's file it said, '[Name] likes to be involved in planning things in his life and can make decisions with little input from staff. [Name] understands the importance of taking medicines'.

People's dignity and privacy were respected. All personal care tasks were provided in people's own rooms.

Curtains and doors were closed prior to any tasks taking place. Staff knocked on doors that were closed before entering people's rooms. We saw staff speak to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Staff had received diversity and equality training.

Where people needed support at difficult times, such as going in to hospital, staff had ensured that any distress was kept to a minimum. For example, staff provided some support whilst they were in hospital to make sure they had a friendly and familiar face. They also assisted hospital staff to more effectively communicate and to understand a person's likes and dislikes.

Staff had been trained in end of life care. The service had built up good links with the local learning disability team and palliative care network for people with learning disabilities. The service had jointly hosted the annual Palliative Care workshops locally for the past two years, using their experience of supporting people with a learning disability at the end of their life. A member of staff had been nominated for a palliative care award.

Some people had been supported to record their wishes about plans in the event of their death. This included where they wanted to die, whether they wanted to be buried or cremated. Details such as favourite flowers and hymns were detailed. This meant people's wishes had been recorded so that when the time came, staff would be able to honour these wishes and to comfort the families.

We heard about a person who had died and the staff had been asked to arrange the funeral. The people the person had lived with were asked if they wanted to help organise the funeral. One person was keen to do this and was involved in making choices such as what songs to sing at the funeral. They were involved in scattering the person's ashes and they still visit to lay flowers. The person likes talking about the deceased person, remembering the good times.

Good

Is the service responsive?

Our findings

People's needs had been assessed. This provided information to develop personalised support plans to reflect people's care needs, choices and preferences and how these were to be met. People's care records reflected all of their needs including physical, emotional and social support needs.

The service had used person centred planning to record how individuals expressed their likes and dislikes, how they wished to be supported, and what their aspirations were for the future. Each person had a 'One Page Profile' to reflect the person and how they wanted to be supported. We saw a person's support plan contained information about their preferred name, details about their personality and what they liked and didn't like. For example, one person did not like loud and sudden noises. The support plan contained information about the person's interests and hobbies, such as listening to music and watching television. People's care needs had been reviewed with them regularly to ensure the information was up to date and reflected current needs.

People were able to keep relationships that mattered to them such as family, friends and other links. There was information in their plans about family members with photographs. We saw a person stayed with their relative regularly and details of who was in the family. We saw a plan called My Story which had information about where the person used to live and with whom. It talked about achievements, for example, one person had done a particular activity for their 50th birthday which they had always wanted. Dreams and hopes were listed such as going on a cruise.

People were encouraged to play an active part in determining their support though one to one meetings with their keyworkers, through person centred plans and as a group of residents meeting regularly, as part of the 'Voices to be Heard' group. People had been involved in staff recruitment, including being part of the formal interview, or observing an applicant's interaction with people as part of an activity/session. We saw that four people had chosen to move to another property that met their mobility needs better and had also chosen who they wanted to live with. Another person had been supported to move to a supported living house in a local town. The person had been keen to move into a town for some time, and the service worked closely with the person's family and the local authority to achieve the goal.

People were protected from social isolation and loneliness. We saw that people were involved in activities that interested them and were encouraged to maintain interests and hobbies. These included activities at the local site but also in the community. For example, activities during the week included art sessions, shopping, going to the pub for meals, visiting the cinema or theatre. Future wishes were recorded such as taking up horse riding and going to see a particular musical. We saw one person who was sociable had listed house parties, social gatherings and birthday celebrations as things they enjoyed taking part in.

The service had a range of choices such as a social club, club nights, fancy dress discos, storytelling, quiz nights and beauty and relaxation nights. People had been on a trip to the seaside the day before the inspection and we saw another trip to the seaside had been planned for the beginning of July.

There were a range of ways people could feedback their experience of care and raise any concerns they may have. Information was provided in an easy read, pictorial and accessible format. The information contained contact details for advocacy groups and the CQC. We asked a person how they would let someone know if they were unhappy about something. They said, "I'd talk to [name] if I was worried, but I never am." We looked at two complaints not related to people in the service. We saw that these had been resolved in line with the provider policy and timescales.

People and relatives had opportunities to provide feedback about the service and their views were respected and considered. For example, house meetings had been held at a local pub. The notes recorded that items discussed included upcoming day trips and what was needed, such as getting a new swing and replacing a shower curtain in someone's house.

Requires Improvement

Is the service well-led?

Our findings

Whilst we found the day to day management of the service was well led, we found the provider had not ensured that the systems and processes in place to highlight where improvements were needed had always been acted upon. We saw audits that had identified where quality and safety of the premises needed improvement. However we did not see that these had been acted upon without delay. This meant the premises had not undergone the necessary improvements to ensure that people had homes that were free from odours and were well maintained, including flooring and décor. There was no evidence to demonstrate that the provider was following nationally recognised guidance to ensure the quality and safety of the premises met expected standards.

Two professionals we contacted felt that communication with the service could be improved. One commented, "The only negative is that they can be slow to reply to emails." Another said, "At times communication can be difficult which can produce a delay in the support we can offer."

Since the last inspection, two managers had registered with the CQC to become registered managers of the service. Each manager had responsibility for particular houses and the staff working in them. All of the people we spoke with told us they thought the service was managed well. One person told us, "[Name] is the manager. She's brilliant at doing things. Everybody likes her." We observed both registered managers interacting with people in the service and with staff.

Staff knew their roles and responsibilities and understood what was expected of them. Staff felt supported by their managers. One staff member told us, "My manager is supportive and friendly." Another staff member said. "They are always at the end of the phone if needed."

Staff we spoke with were familiar with the provider's whistleblowing policy and they were confident to raise concerns. Whistleblowing is the process for raising concerns about poor practice.

Quality assurance systems not related to the premises, were robust. The provider also had a number of online systems for capturing information and monitoring data for safeguarding incidents, accidents and incidents, safety audits and complaints and compliments. These systems were reviewed and monitored by senior managers who would report to the provider's health and safety groups and other regulatory authorities.

We found risks related to the premises and environment. However, other risks in respect of people's care were anticipated, identified and managed by thorough risk assessment, monitoring of patterns and trends, and learning from investigations. For example, we saw a health and safety report which detailed the number of incidents and accidents for a certain period. The incidents had been reviewed to ensure that the positive behaviour support guidelines had been followed, or were reviewed and amended.

Assistive technology was in place, where necessary, to protect people such as door alarms, fall sensors and epilepsy monitors. This technology was checked regularly to ensure it was in working order. Where action

was needed, we saw this was followed up. For example, a chair sensor was not working correctly. We saw it was reported and fixed within two days.

The service worked in partnership with key organisations such as the learning disability teams, health professionals and were members of the local Oxford Association of Care Providers (OACP) and attended their meetings. The service were members of the local PCPLD (Palliative Care network for People with a Learning Disability) and attended events run by OxFSN (Oxfordshire Family Support Network). The registered managers were members of local networks such as the Autism Network, the local Volunteer network, and other learning disability groups such as 'Mates and Dates' and 'My life My Choice'. These benefitted people. For example, advice was sought on behalf of a couple living in the service. One of them has dementia and the service worked closely with a psychologist from the local LD team. This was to support both the person to understand their dementia diagnosis, but also with the person's partner to help them understand the nature of the condition and what was likely to happen to the future. It helped both of them make an informed choice about their future.

The service took measures to ensure they kept up to date with developments in learning disability practice. The PIR stated this was achieved by holding monthly management meetings to provide feedback on national initiatives both within HF Trust and nationally. Information was provided by registered managers to feedback to regional meetings and learning disability forums. For example, feedback from managers to the learning and development team, planning of the staffing re-structures and reviews, and the national review of the 'on call' system used within HF Trust. This meant people in the service received care in line with current good practice.

Team meetings had taken place and staff were encouraged to have their say and feedback on issues in these meetings. A member of staff said they were able to discuss things openly at the meetings and discuss any problems, or any changes that staff needed to be aware of.

The service benefitted from HF Trust having membership with organisations who had expertise about people with learning disabilities. These included, British Institute for Learning Disabilities (BILD), Challenging Behaviour Foundation, Housing and Support Alliance, Alzheimer's Society, Downs Syndrome Association, Dementia Action Alliance. Accreditations include Silver Investors in People and BILD approved Positive Behaviour Support Practitioners. The service was also working in partnership with the Tizzard Centre to create a person centred active support organisation. This meant the service had access to areas of excellence to integrate into people's care and support.

The provider had policies and procedures in place for all areas of the service including safeguarding adults, positive behaviour support, managing medicines and consent to support. Staff could access these from the provider's intranet site.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered managers of the home had informed the CQC of reportable events.

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 15 HSCA RA Regulations 2014 Premises and equipment People who use services were not protected against the risks associated with unsuitable premises because of inadequate maintenance. Regulation 15 (1)