HF Trust Limited

HF Trust - Orchard View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
HF Trust - Orchard View is a residential care home providing accommodation for persons who require personal care and have a diagnosis of a learning disability and/or autism. The home can accommodate 6 people and at the time of the inspection, 6 people were receiving support.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
People did not always receive person centred care in line with Right, Care, Right Support, Right Culture.

Right Support: People had limited opportunities to leave the service and pursue social interests within their local community. Where people had been allocated one to one staff support to complete meaningful activities, people had not always received this support. There was limited guidance to inform staff how to enrich people's lives through positive engagement and meaningful activities. People's goals and aspirations were not always identified with people or those involved in their care. Risks associated with people's health and wellbeing were not always managed safely. Where risks had been identified, some records contained conflicting information about how staff should manage these risks.

People were not always supported to have maximum choice and control of their lives, but staff supported them in the least restrictive way possible and in their best interests; the providers policies and systems supported best practice, but these were not always followed by staff.

Right Care: People were not always involved in making decisions about their care. There was limited consideration given to the varying ways people could be empowered to make everyday choices using different communication methods.

Right Culture: The service did not always have a person-centred culture which empowered people to achieve their goals and aspirations. Systems were not operated effectively to identify if people were receiving person centred care in line with Right Care, Right Support, Right Culture. There was insufficient recording and reviewing of behaviours where a person had experienced distress.

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

Rating at last inspection
The last rating for this service was good (published 3 October 2019).

Why we inspected
We received concerns in relation to safe staffing numbers and governances. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. Please see the safe, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for HF Trust – Orchard View on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, person centred care and good governance at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

HF Trust - Orchard View

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out this inspection. A third inspector completed telephone calls to relatives to seek feedback about the care provided at HF Trust – Orchard View.

Service and service type
HF Trust – Orchard View is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. HF Trust – Orchard View is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was not a registered manager in post. An interim agency manager had been employed to provide short-term managerial oversight and the provider was actively recruiting a new registered manager at the time of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We met with all of the people who lived at HF Trust – Orchard View. We spoke with 1 person and 3 relatives about their experience of the care provided. We spent time observing how staff interacted with people. We spoke with 7 members of staff including 2 support workers, 1 senior support worker, 1 temporary staff member supplied through an agency, the interim deputy manager, the interim agency manager and the residential operations manager. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included information contained in 3 people's care records and samples of medicine and daily records. We also looked at 1 staff recruitment file and records related to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant 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.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks associated with people's health and wellbeing were not always managed safely. Where risks had been identified, some records contained conflicting information about how staff should manage these risks.
- One person was at risk of choking and their care plan stated they should remain in an upright position for 30 minutes after eating. This guidance was not known or followed by staff. During our visit the person was tilted backwards in their wheelchair a few minutes after their meal, putting them at increased risk of choking.
- The same person needed to be supported to wash their skin twice daily to manage a skin condition and reduce the risk of skin damage. Although we found no evidence this person had been harmed, records did not consistently show this was being done which increased the risk of harm.
- Some people living at HF Trust – Orchard View had complex conditions which required very careful and considered care planning to minimise the likelihood of distress. Records did not always contain enough or accurate detail to enable staff to support people to manage their behaviour safely. For example, 1 person was at high risk of self-injurious behaviour. There was limited guidance on how staff should respond to this behaviour to keep the person safe.
- Medicines were not always stored, administered or managed safely. Some people needed medicines on an 'as required' (PRN) basis to treat short term conditions such as pain or anxiety. Where medicines had been prescribed to help people manage levels of distress, it was not always clear when these medicines should be considered as guidance contained vague information such as 'to manage extreme mood'. This increased the risk of these medicines not being given by staff in a consistent and appropriate way.
- The provider could not evidence a clear rationale for the administration of some PRN medicines. Staff had not completed sufficiently detailed records to show these medicines were always given as a last resort. There was no evidence to show whether these medicines had been effective to enable a robust review by clinicians.
- Improvements were required to the safe storage of medicines. Some medicines needed to be stored below 25 degrees to ensure their effectiveness. A large quantity of people's medicine stock was kept in the office which was not temperature controlled.
- Medicine administration records (MAR) did not always follow best practice guidance. For example, 1 person's prescribed emergency medicine was not listed on their MAR. Handwritten entries were not always double checked to prevent errors and a short-term amendment to a person's medication had not been changed on their MAR.

We found no evidence people had been harmed but systems and processes failed to demonstrate risks associated with people's care were effectively managed. This was a breach of regulation 12 (Safe Care and

Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the interim agency manager took some immediate actions to mitigate these risks. For example, a healthcare professional was contacted to review a person's choking guidelines, a new positive behaviour support plan for self-injurious behaviour was implemented and new protocols around the management of PRN medicines were introduced.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Although records showed the home was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty, this was not always reflected within staff practices.
● It was not always clear how people had been involved in decisions about their care. Records did not always show how staff had taken all reasonably practicable steps to empower people to make decisions about their care.

Learning lessons when things go wrong
● An electronic system was in place to monitor accidents and incidents. However, this was not effective because incidents were not always recorded appropriately.
● There was limited oversight to ensure any patterns or trends were identified quickly. Where incidents had been reported, it was not always clear if these had been reviewed to prevent re-occurrence.

Systems and processes to safeguard people from the risk of abuse
● Staff received safeguarding training to help them recognise potential signs of abuse or neglect and understood their responsibility to report any concerns. One staff member told us, "It's about protecting people from harm. Anything you think is harmful you would report. Neglect, abuse, anything that was affecting the person. I'd be confident reporting something if I was concerned."
● Some staff told us they had raised concerns about people's emotional and social welfare with management as people were not always supported in a proactive way. We have reported further on this in the 'Responsive' section of this report.

Staffing and recruitment
● There were enough staff to provide safe care. However, a number of permanent staff had left following changes in the provider's structure and the home was heavily reliant on temporary staff supplied through and agency.
● Staff were recruited safely. Pre employment systems included reference and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There were no restrictions on visiting. Friends and family could visit when they wanted to.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person centred care in line with the principles of Right Care, Right Support, Right Culture.
- Following the COVID-19 pandemic, people had not always been re-introduced to things that enhanced their emotional and social well-being. One relative told us, "The trouble is, [Person] is in the house a lot and they are very much an outdoor person. [Person] is cooped up there the majority of the time and is not living their life to the full."
- We reviewed 3 people's records and found limited evidence of people pursuing their individual hobbies and interests both within the home and in their local community. For example, one person enjoyed swimming and their care plan stated they should be supported to go swimming once a week. There were no records to evidence this person had been swimming since before the COVID-19 pandemic and staff confirmed this.
- Another person's records described how they enjoyed spending time in the community such as attending local events or discos. Records showed significant periods of time where this person had not left the home except for visiting the on-site day centre.
- Some people had been allocated specific one to one staff support to enable them to pursue individual interests or activities meaningful to them. People had not always received this support. For one person, these hours were agreed for them to enhance their quality of life by taking part in recreational activities they enjoyed. Records did not show this support was provided. One staff member said, "[Person] has over 40 one to one hours each week. I can't remember the last time [person] went out."
- Feedback from staff confirmed time spent away from the home was rare and changes at the service had a negative impact on the atmosphere in the home. One staff member said, "More often than not we're in the house, not out and about." Another commented, "I miss the laughter in the house. The ladies used to have so much fun."
- There was limited guidance to inform staff how to enrich people's lives through positive engagement and meaningful activities. People were not being supported to try or experience new things and there was limited information about people's individual goals and aspirations. Because of this, there was no direction for staff on how they should support people to spend their time on a daily basis.
- People were not always encouraged to complete meaningful activities or maintain their skills within the home. There was a culture of staff doing things for people rather than encouraging people to do things for themselves. For example, one person's care plan included guidance for staff on how they could include this person in cooking and preparing their meals, using hand on hand support. This was not encouraged on the day of our visit and records did not show how staff supported people to maintain their skills at other times.

● There were missed opportunities to spend meaningful time with people to encourage social stimulation and interaction. One person spent the morning in their bedroom with limited attempts from staff to engage with them. Another person spent the day in the lounge making pom poms with limited interaction from staff. Some daily records reviewed simply stated, "Spent the day walking around the house."

We found no evidence that people had been harmed but people did not receive person centred care which ensured people had choice and control which met their needs and preferences. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Records contained detailed information about people's preferred method of communication. However, there was limited evidence to show how important information had been made accessible for people.

Improving care quality in response to complaints or concerns
● There had been no recorded complaints in the past 12 months. A complaints policy was in place and in a format people could understand. However, this was not always actively promoted, and people were not always encouraged to give feedback on their experience of care.

End of life care and support
● At the time of our visit, no end of life care was being provided and we were confident that in an emergency, staff knew how to respond to ensure emergency medical assistance was sought.
● However, records did not always show people's end of life wishes or preferences had been considered.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There had been some significant managerial changes at the home. The previous registered manager and deputy manager had left 2 months prior to our inspection. The provider had employed an interim agency manager to maintain managerial oversight on a short-term basis. The provider was in the process of interviewing candidates for the registered manager role at the time of our visit.
- There had also been significant changes within the provider's senior management team. Senior managers who had been overseeing the quality of care at the home for the past 12 months had either left the organisation or had been re-deployed. A recent provider restructure meant senior managers from other areas of the provider group were now responsible for senior managerial oversight of the home. However, they had not yet had time to familiarise themselves with the improvements required at HF Trust - Orchard View.
- The provider had been open and honest with the interim agency manager about the improvements required at the home. The culture within the home had been identified as one which did not always promote an open, person-centred and inclusive service. A deputy manager from one of the provider's other locations had been seconded to help the interim agency manager improve the culture and drive forward improvements.
- The provider's aims and values of providing person-centred care through their 'Fusion Model of Support', where people are engaged in meaningful activity and relationships as active participants, was not embedded at the home. Some staff felt this was due to the lack of strong leadership and direction.
- Staff consistently provided negative feedback about how the managerial changes had impacted them and told us morale was low. One staff member told us, "Staff morale is not great, hasn't been for a while. We were disclosing things to management which weren't changing or acted on. We felt de-valued and not supported. It's been hard with all the changes." Whilst they spoke positively about the support received from the interim agency manager and the seconded deputy manager, they told us the home needed long term stability.
- Quality assurance processes were not always effective. The provider's internal quality assurance team had recently completed a compliance audit which had identified a number of the concerns we found during our inspection. However, timely action had not been taken to drive forward the required improvements.
- Regular internal checks on quality had not always identified the concerns found during our visit such as incident reports not always being completed, medicine management issues and discrepancies with the

management of risk in care plans.

The provider's oversight and governance systems were not always operated effectively in assessing, monitoring and improving the quality and safety of the service provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed our concerns with the residential operations manager and the nominated individual who were responsive to our feedback and took some immediate actions to ensure people received safe care. For example, they reviewed any immediate risks, sought advice from healthcare professionals and introduced new medicine protocols.
● A director from the provider company also arranged a meeting with staff to increase staff morale and aid communication.
● The interim agency manager had devised a robust action plan. This included reviewing people's care and social well-being with people and their relatives. Re-training had been arranged for staff in 'Person Centred Active Support' and tasks had started to be delegated to senior staff members to ensure they felt fully involved with the improvements being made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● It was not always clear how people using the service had been involved in their care in a meaningful way. There was limited evidence to show people were able to provide feedback about their care.
● Some team meetings had taken place, but staff did not always feel listened to. One staff member explained how they had repeatedly tried to re-start an activity for a person as it was important to them but had not received senior managerial support.
● Relatives also raised some concerns about communication from senior management. One relative told us, "There are concerns around Orchard. The manager has left, and it has gone down like a pack of cards. The deputy has gone and lots of good staff have left. The managers at the next level up never seem to be open and honest about what is going on."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibility to be open and honest when things had gone wrong.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12(1) The provider had failed to ensure care and treatment was provided in a safe way for service users. 12(2)(a) The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment. 12(2)(b) The provider had failed to do all that was reasonably practicable to mitigate any such risks. 12(2)(g) The provider had failed to ensure the proper and safe management of medicines.

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 9 HSCA RA Regulations 2014 Person-centred care 9(1) The provider had failed to do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. 9(3)(a) The provider had failed to carry out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. 9(3)(b) The provider had failed to design care or treatment with a view to achieving service users' preferences and ensuring their needs are met. The provider had failed to ensure care and treatment was designed to meet people's needs and make every reasonable effort to meet people's preferences. 9(3)(d) The provider had failed to enable and support relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible.

The enforcement action we took:

Serve Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) The provider had failed to ensure systems and processes were established and operated effectively to ensure compliance with the requirements in this Part.

17(2)(a) The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

17(2)(b) The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

17(2)(c) The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect to each service user.

The enforcement action we took:

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