HF Trust Limited

HF Trust - Devon DCA

Inspection report

28-31 Teignbridge Business Centre
Cavalier Road, Heathfield Industrial Estate
Newton Abbot
Devon
TQ12 6TZ

Tel: 01626839930

Date of inspection visit:
06 December 2016

Date of publication:
30 January 2017

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

HF Trust – Devon DCA (Hft) is part of a larger national provider for people with learning disabilities and is registered to provide personal care to people living in the community. At the time of this inspection the service was supporting 35 people with varying support needs in a total of 13 supported homes. Some people lived alone, requiring minimal support and others lived in shared accommodation with support both during the day and overnight.

This unannounced focused inspection took place on 6 December 2016. It was undertaken in response to concerns raised with us about people not receiving safe care and treatment, and the staffing arrangements within the service.

The service was previously inspected in April 2016 when it received an overall rating of good, with the key question of well-led rated as requires improvement in relation to how the service was managed.

Since that inspection there had been changes to the management structure within the service. In April 2016 there were two registered managers in post, each with a responsibility for a geographical area. At the time of this inspection in December 2016, the service had one registered manager with the responsibility for both geographical areas. 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.

At this inspection, we found the high use of agency staff unfamiliar with people's care needs had led to some people being placed at risk of not receiving safe care. Some people were also reluctant to receive assistance from staff they did not know well and people were not always supported by their preferred gender of staff.

We made a recommendation that the service keeps its staffing arrangements under review.

Although staff had access to people's care records, these did not always provide an accurate account of each person's support needs. Daily care and monitoring records were incomplete and it was not always possible to ascertain the care and support provided to people.

The service's management team had taken steps to improve the consistency within the staff team. They were aware of the need to improve the support and were working closely with the local authority's quality assurance and improvement team.

We found the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the service to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could not be assured of receiving safe care and support. The high use of staff unfamiliar with people's care needs did not promote personalised care.

Care records were insufficiently detailed to guide staff with meeting people's care needs and maintaining their safety.

HF Trust - Devon DCA

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 focused inspection took place on 6 December 2016 and was unannounced. One social care inspector undertook the inspection. Prior to the inspection we looked at the information we held about the service. This included correspondence we had received about the service and notifications of events they are required by law to send us.

During the inspection we reviewed the care records for four people living at one of HF Trusts' services. We spoke with a staff member, the registered manager and the service's regional manager. Following the inspection we met with the local safeguarding and learning disability support teams, as well as the registered manager and regional manager to review the information of concern received about the service.

Requires Improvement

Is the service safe?

Our findings

In November 2016 the local authority's learning disability Intensive Assessment and Treatment Team (IATT) and the safeguarding team shared concerns with us about the staffing arrangements at one of the homes supported by the service. The concerns related to people not receiving safe care and support and the high use of agency staff unfamiliar with people's care needs.

At the time of this inspection, there were five people living at this home. Concerns had been raised about three of the five people. Staffing levels were determined by an assessment of each person's care needs and whether there were any risks associated with their needs. The registered manager told us the service obtained staff from an agency to support the service's own team of staff and whenever possible they were provided with the same staff. However, some of the staff from the agency were new to the service and unfamiliar with people's care needs. This had led to some people being reluctant to receive assistance with their personal care and other aspects of some people's support had not been managed safely.

Two women living at the home required the assistance of female staff to support them with their personal hygiene needs. At times only male care staff had been available and neither person was willing to accept support from male staff. This had led to these two people not having their personal care needs consistently attended to and occasionally there were times when they were unkempt and unclean. The registered manager confirmed there was now always female staff available to support the women living in the home.

One person had specific support needs in relation to how they ate and drank. The service provided some guidance for staff about how to encourage this person to eat. The person's care plan identified they had been prescribed nutritional supplement however, there was no evidence on the food and fluids records that these had been provided. In addition, due to this person being unfamiliar with some staff, they had been reluctant to eat. We were told by IATT in November 2016 that this had resulted in the person losing a significant amount of weight. Following the inspection, the registered manager and a senior member of staff confirmed that training had taken place with staff who knew the person well and those agency staff identified to work with this person. They had discussed how to support them more consistently and this had resulted in the person increasing the amount they were now eating and drinking.

Two people had epilepsy which required them to have constant staff support during the day and evening to maintain their safety should they have an epileptic seizure. Both people required staff to administer emergency medicines should they fail to recover from a seizure. However, there had been occasions when one person had been left alone during the day. This meant that should the person have a seizure staff were not able to support them or administer the required medicine in an emergency. The registered manager said there had been some confusion within the staff team about whether this person could be left alone for short periods of time as well as from what time in the evening they could be left alone. IATT confirmed this person must not be left alone until they had gone to bed. The registered manager confirmed that staff would remain with this person at all times. They confirmed that assistive technology, including epilepsy sensors and door alarms, were in place for both people to alert staff should they have a seizure once they were in bed. The registered manager said the service only accepted staff from the agency who had received training

in supporting people with epilepsy and who could administer the emergency medicine.

Staff employed directly by Hft and agency staff were not aware of a significant issue regarding one person's care. This had led to the person having access to equipment when this posed a threat to themselves, staff and the other people they lived with. The registered manager confirmed there had been a lack of communication between those staff who knew the person and those staff new to the home. Assurances were given that no harm had come to anyone at the home as a consequence and all staff were now aware of the need to keep equipment locked away.

Failure to provide people with safe care and support is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records related to the safety of four people living in the home. Each person's file held a 'pen picture' and a summary of the essential information about how to support each person. These provided staff with easily accessible information about people's care needs. However, the remainder of the care records were lengthy and staff unfamiliar with the home would need time to fully review each person's care file before starting to support people.

We found some of care records were incomplete and did not provide a contemporaneous account of people's care. For example, staff had not kept consistent daily records of one person's care for 12 days during November and December. Some care records did not accurately reflect the care and support people required. For example, the care records relating to the person who required support with their eating and drinking were not sufficiently detailed to make sure staff provided personalised care. Staff had not been keeping an accurate record of how much this person had been eating and drinking. Records showed that on some days this person had eaten very little. In addition, the records of when one person had experienced epileptic seizures could not be found.

Failure to maintain accurate and complete records in relation to people's care is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection there were three male staff and one female member of staff on duty: all of whom were employed directly by the service. The duty rota showed that some agency staff were booked to work at the home. The service's regional manager said they had asked for agency staff to be 'block' booked to provide consistency and for staff and people to become more familiar with each other. The duty rota showed a number of agency staff had been block booked for several shifts both for the week of the inspection and the following week. The registered manager confirmed they were advertising for permanent staff and had arranged a number of interviews. Following the inspection they confirmed they had appointed three new members of staff for the home.

We recommend the service keeps under reviews its staff arrangements to ensure sufficient suitably qualified, competent, skilled and experienced staff are provided to enable the service to meet people's needs.

The regional manager said the service was committed to improving the care and support provided at the home. The registered manager was working at the home at least one day a week to support the staff. They said more detailed handover reports had been provided for staff. They also confirmed agency staff would only be accepted if they had previously worked at the home or, if new, had completed an induction. They were also working with the local authority's quality assurance and improvement team (QAIT) and with them had developed a service improvement plan.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People supported by the service were placed at risk by not receiving safe care and treatment. Regulation 12 (1)(2)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was failing to maintain accurate, complete and contemporaneous records in respect of each person's care. Regulation 17(2)(c)