Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

HF Trust - Pound Lane - Herts and Essex DCA

Bradbury Resource Centre,, Pound Lane, Ugley, Bishops Stortford,, CM22 6HP

Tel: 01279816165

Date of Inspection: 18 February 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	HF Trust Limited
Registered Manager	Mrs. Sara Louise Stoker
Overview of the service	HF Trust - Pound Lane provides accommodation and support in a residential environment for people with learning disabilities, some of whom may also have physical disabilities. HF Trust also provides a domicilliary care service where people with learning disabilities receive care and support in their own homes in the community.
Type of services	Care home service without nursing Domiciliary care service
Regulated activities	Accommodation for persons who require nursing or personal care Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

When we inspected HF Trust - Pound Lane on 18 February 2014 we found that people were asked for their consent to receive care and support. Two people we spoke with in the residential centre confirmed that staff always asked their permission whenever they provided support.

We found that the service acted in accordance with legal requirements when people did not have the capacity to consent. The relative of one person receiving this service said, "I think HF Trust generally gets the balance right between helping [name] to make their own decisions and making decisions on [name's] behalf."

People's needs were assessed effectively and care was planned and delivered in a way that ensured their safety and welfare. One person told us that they got everything they needed from the staff and said, "They [staff] are all good people. They do what I need." The relative of one person receiving the domiciliary service told us, "They have looked after [my relative] very well. There is nothing that [they] don't get if [they] need it."

We found that there were appropriate arrangements in place to administer and store medicines. People's medicine records were accurate and up-to-date.

People were cared for by staff who were properly supported to deliver care safely and to an appropriate standard. This was because staff received regular training that was relevant to their role and were supported through an effective supervision programme.

The provider operated an effective system to monitor the quality of the service that involved a review of people support plans. The provider also took account of the views of people and their relatives.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

When we inspected HF Trust – Pound Lane on 18 February 2014, we found that people who used the service were asked for their consent to receiving care and support. This was the case for both the residential service and the domiciliary service operated independently from the same location.

The manager of the residential centre explained that one of the principal goals of people living there was to increase their level of independence. This included their independent decision making and their expression of choice. One staff member we spoke with told us, "It is really important to give people options and give them the chance to choose. Sometimes you have to go over it two or three times and explain it in different ways to make sure they understand before they agree to it." Two people we spoke with in the residential centre confirmed that staff always asked their permission whenever they provided support.

We saw such permission being sought during our observations of a number of informal interactions between support staff and people who were living there. We saw that staff members were always courteous and respectful to people and that they asked people for their agreement to carry out routine, daily tasks. For example, we observed one staff member talking to a person about what their plans were for the day. The conversation centred on the person's wishes, such as what they would like to do and whether they wanted to be supported from the lounge to go into a different part of the building. The staff member explored different options with the person and waited for a response each time. It was clear to us that it was the person who was in control of the decisions and that the staff member was asking questions to ensure the person understood what they were being asked to agree to.

We also looked at the records relating to three people living at the service. We noted that appropriate processes had been followed to determine people's capacity to consent to certain aspects of their care and support and that decisions had been taken in their best interests where this was necessary. For example, we saw that one person's particular medical condition meant that their diet required strict controls to prevent them from eating things which would be harmful. We saw that the person's capacity to make decisions about this aspect of their care had been thoroughly assessed and a decision taken on their behalf to restrict their access to this particular food.

We saw that the same philosophy on independent decision making extended to the domiciliary care service. The relative of one person we spoke with said, "HF Trust have supported [my relative] to become more independent."

We also noted that an advocacy service had been commissioned to provide assistance to some of the people in relation to expected changes in their accommodation arrangements. This showed that people's best interests were protected in relation to an important decision that affected their lifestyle.

We looked at the records of three people who were receiving a domiciliary support service. We noted that their capacity to make decision about a range of different aspects of the care they received had been properly considered. For example, evidence showed that a particular decision had been made on behalf of, and in the best interests, of one person. This was because they had been assessed as having insufficient capacity to understand the consequences of unsupervised access to something which could cause them harm.

In another person's records we found evidence showing that they had been assessed in relation to their capacity to consent to support with their medication. The assessment concluded that there was no evidence of the person being unable to understand the risks and benefits involved. Therefore, there was no resulting need to make a decision on their behalf.

The relative of one person receiving this service said, "I think HF Trust generally gets the balance right between helping [name] to make their own decisions and making decisions on [name's] behalf." This showed that the provider followed proper processes to ensure people's rights were protected.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care was planned and delivered in line with their individual needs. People who were living in the residential centre had their own rooms in four separate blocks, referred to by the staff as 'homes', each of which had its own communal facilities. Each person lived in a home alongside other people with similar needs. This meant that people could receive the same levels of support and experience a similar degree of independence as the people they associated with from day-to-day.

People we spoke with were positive about the way their needs were met. One person told us that they got everything they needed from the staff and said, "They [staff] are all good people. They do what I need."

We heard similar experiences from people who were receiving the domiciliary service. The relative of one person told us, "They have looked after [my relative] very well. There is nothing that [they] don't get if [they] need it."

We saw that people's needs were comprehensively assessed and their support requirements were planned and delivered effectively. We noted that people's needs were assessed for a variety of different aspects of their lives such as their health, personal care, behaviour, culture and their leisure interests. Following the assessment, achievable 'goals' were set for people that promoted their path towards greater independence. For example, we saw that one person had a goal that was related to their interest in a particular type of transport. To help the person reach the eventual goal of taking a journey on this mode of transport, we saw that there was a planned, stepped sequence of activities that were to be achieved along the way.

The assessment and planning tools used in both the residential centre and the domiciliary care service took the form of a computerised care management system and written documentation. Staff we spoke with told us they found the system helped them to understand people's needs and to deliver the care and support that people needed at any given time.

We noted that people's support requirements were kept under regular review. The frequency of the reviews varied depending upon the type of need or whether any changes

in people's behaviour or their situation had been noted on an evolving basis. Such changes were noted by staff whenever a person's support plan was deviated from. One of the staff members we spoke with explained how this worked in practice.

We saw that one person's behaviour had undergone some changes due to the effects of their medication. The changes had been noted in a handover records entry for oncoming staff that support the verbal exchange of information at the beginning of their shift. We saw how this had led to amendments in the person's support plan. This meant that staff could be assured of being able to access up-to-date information about people's needs. One staff member who was working at the residential centre told us, "I sometimes refer to the [name of the computerised system] as it's got everything on there. But I also always check the hard copies in people's support plan and the handover information."

Care and support was also assessed, planned and delivered in a way that ensured people were kept safe. We saw that risks relating to people's daily activities had been assessed and that control measures to mitigate such risks had been put into place. These risk assessments were specific and related to each person. For example, we saw a 'missing person' contingency plan for one person. This plan contained all of the information, including a relevant photograph that could be handed to the authorities in the event that the person went missing.

We also found that there was an effective mechanism in place for identifying and assessing sudden, significant changes to people's needs that might result in them being harmed. For example, we saw that one person's behaviour had changed suddenly. This had resulted in a set of 'crisis' guidelines to help staff support the person and to help to manage their behaviour. The guidelines had been issued to all staff through a secure email and communicated during handover and team meetings. This ensured that staff were alerted and were enabled to meet this person's immediate needs to keep them safe.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Appropriate arrangements were in place in relation to obtaining, recording, handling, keeping and administering medicine. We saw that the provider had recently changed the pharmacy that supplied people's medication. One person had been employed specifically by the provider to oversee the reception of medicines at the residential centre.

We noted that there were secure arrangements for access to the keys to the medication storage. Two people had their own locked cupboards for storing their medicine and this reflected their level of independence.

There was also a list of staff who had received appropriate medicines training and who were thereby authorised to handle and administer medicines. Similar arrangements were in place to train and authorise staff to administer medicine to people receiving the domiciliary service.

We noted that, generally, people's medicines were administered at four separate time slots during the day according to people's prescriptions. However, where administration of particular medicines was time critical, arrangements were in place to ensure that they were given when they should be. For example, an item of medicine for one person had to be given at precisely 6am as opposed to being given with breakfast and we noted that night duty staff routinely carried this out on time.

People who lived at the residential centre told us they thought that they always received the medicine they were meant to have and at the time they were meant to have it.

We looked at the medicine administration record (MAR) sheets of three people who were using the service and found that they contained sufficient relevant information, including a photograph, to enable staff to administer medicine accurately. The MAR sheets were accurate, up-to-date and correlated with people's prescription. There were no omissions in the records. This signified that medicines had been administered appropriately.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development. We looked at staff records and spoke with staff members from both the residential centre and the domiciliary service. We saw that there was a comprehensive scheduled training programme that incorporated a range of training that the provider had deemed as mandatory. Such programmes included, biennial safeguarding training and annual fire safety and health and safety training.

The training schedule included a blend of delivery media, such as e-learning, classroom based training and workplace mentoring. For example, we noted that the annual moving and handling training involved e-learning as well as face-to-face training to allow staff the opportunity to practice their handling techniques. Some of the training programmes, such as medication administration, involved an assessment of the staff member's competency prior to them being able to carry out that function independently.

The provider had recently launched a new on-line learning and reference point known as the 'Knowledge Centre'. Staff we spoke with said that they felt this would enhance their role. One staff member told us they thought they would have "…knowledge at your fingertips".

New staff received a comprehensive induction programme centred on the national standards set out by the care sector skills council. This induction programme incorporated written literature, mandatory training and a competency assessment of a range of relevant skills in the workplace. One member of staff who was undergoing this process told us that they thought the programme was "…absolutely thorough; I am learning things all the time with my supervisor".

Staff were also supported through annual appraisals, regular one-to-one supervision sessions and staff meetings. We looked at supervision and appraisal records and noted that supervisors considered staff members' performance, their personal development and their wellbeing. Personal development plans were driven by achievable and relevant objectives. This ensured that staff were skilled and competent at, and confident in, their roles.

Staff members who told us they felt supported by the management team. One staff

member from the domiciliary service told us that this support was not confined to supervision but extended to support in the workplace too. They said, "The management are very hands on. When one of our residents [became seriously unwell] the managers were really hands on, doing extra hours to support the staff."

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who were using the service, their representatives and staff were asked for their views about their care and they were acted on. The relative of one person who was receiving support in their own home told us that they had taken part in an annual review. They said they had raised an issue at the meeting about communication from the service over receiving updates about what was planned for their relative. They told us they had noted that some recent re-organisation had led to improvements in this area.

We saw that people who were using the domiciliary service were routinely asked for feedback about their support workers to assist in the appraisal process. They were also asked whether their views could be shared with relevant staff members during the process. One staff member told us they felt that this ensured that assessments of their performance were relevant and meaningful.

The service ran a twice-yearly forum entitled 'Friends and Family' where relatives of people who were using the service were asked to contribute their views on it. We looked at the records of the meeting held in November 2013 and saw that the provider's senior regional management and quality assurance staff had attended. We reviewed the notes of the discussions held between the senior panel and the families and friends who were there. We noted that feedback was acknowledged by the senior team and that actions had been generated to resolve areas that were seen as requiring improvement. Such issues included; suggested improvements to the way that feedback from people's relatives were sought, suggestions about improving the quality and inspirational nature of the provider's newsletter and actions required to progress the development of the garden centre on site. This showed that the provider ensured that decisions about the quality of the service arising from the views of people and their relatives were made by the appropriate staff at the appropriate level.

We saw that the provider carried out monthly quality monitoring audits. We looked at records of these audits and saw that they were evidence-based, involving the views of people who were supported as well as reviews of their support plans. For example, the January 2014 audit considered a question about the effectiveness of people's communication plans. We saw that people's support plans were reviewed against a range

of criteria; such as whether the person had a communication plan, whether the support plan adequately reflected the person's goals and whether this helped the person to develop new relationships. We noted that the findings in relation to this particular question were largely positive and acknowledged recent improvement work done by the service manager. It also included a recommendation that this work continue in relation to recording progress against people's goals. The service manager explained that recording progress against goals was important and was ongoing. This showed that there was an effective quality assurance system in place that was directly related to the care and support people received.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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