Franklin Homes Limited

Fairways

Inspection report

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Date of inspection visit:
06 May 2021
13 May 2021

Date of publication:
30 June 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fairways is a residential care home providing accommodation and personal care for up to 12 people. The service supports people with a learning disability and/or autism. Eight people were living at the service at the time of our inspection.

People's experience of using this service and what we found
People were not always safeguarded from harm. Concerns raised had not always been addressed and investigated appropriately which meant people were left at risk. There were insufficient amounts of staff to meet people's needs. The service was not always clean and well maintained.

People were not always treated with respect or had their independence encouraged. People's privacy and dignity was not always maintained.

There was a restrictive culture in the service. This included people not being able to access some communal rooms at set times without staff supervision.

The management and leadership of the service had not been effective at promoting a positive culture. Systems in place had failed to address areas of concern we identified at this inspection.

The provider had failed to use complaints and feedback to improve the quality and safety of the service.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Care was not always person centred to promote independence and minimise restrictions. The behaviours of leaders and care staff did not always ensure people using services lead empowered lives. We raised concerns with the locality manager who started to take immediate action to address these areas.

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 21 December 2018).

Why we inspected
The inspection was prompted in part due to concerns received about allegations of abuse, the culture of the service and the environment. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to follow up on specific concerns which we had received. We inspected and found concerns with people's privacy and dignity not being maintained, person centred care and management and leadership, so we widened the scope of the inspection to become a comprehensive inspection of all five key questions.

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.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, the environment, staffing, dignity and respect and governance and oversight of the service.

Please see the action we have told the provider to take at the end of this 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following receipt of the draft report the provider confirmed they had made the decision to close the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Fairways

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 Care Act 2014.

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.

Service and service type
Fairways is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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 used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report

During the inspection
We spoke with three people who used the service and telephoned four relatives about their experience of the care provided. We spoke with the registered manager, locality manager, senior support worker and three support workers. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at five staff files in relation to recruitment, training and staff supervision. We reviewed a variety of records relating to the management of the service, including audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from harm. When a safeguarding concern had been raised, it had not been reported, acted on or investigated. This meant people were left at risk of abuse. We raised these concerns with the area manager who made a safeguarding alert.
- There was a culture of institutional practice. This included restrictions on entering communal rooms and people not being able to see out of the windows. There were rules in place which were not of justified reason, such as people not being allowed phones in some areas or not being able to enter the art room unsupervised. One person was also restricted from having a second cup of tea.

We found systems were not in place to prevent and protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There was no staff awake during the night (both night staff were 'sleep in' staff) and no system in place for people to request support should they become unwell. This meant people did not always receive support they required.
- There was insufficient staff deployed to deliver person centred care and maintain people's privacy and dignity. When care plans indicated people liked to be up early, there was no waking staff available to help them.
- There was insufficient staff to promote people's independence. One staff told us, "You cannot promote independence because you don't have time. You are so busy rushing around doing things."
- There was insufficient staff to support people with duties such as cleaning. People's bedrooms were not always clean and tidy due to this.
- There was no dependency tool to assess the staffing levels based on individualised needs.

We found systems were not in place to ensure sufficient levels of staffing. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider informed us they were in the process of recruiting a staff member to support with cleaning duties.
- Staff recruitment checks had been carried out prior to people starting work in the service.

Learning lessons when things go wrong; Assessing risk, safety monitoring and management

● Lessons had not been learnt from incidents that occurred. For example, incident records and daily notes indicated a culture of restrictive practice but this had not been identified and acted on.
● People's safety was not always maintained. One room was used as a storage room. This had electrical equipment, boxes of records and other items which posed a fire risk. One person who was at known risk from electrical equipment had accessed this room.
● Risk assessments were in place to reduce individual risks to people.

Preventing and controlling infection
● Equipment such as pedal bins were not always in place or were damaged. This meant Personal Protective Equipment (PPE) could not be disposed of safely. Clinical waste bins were not stored securely.
● People's bedrooms required attention. This included carpets which needed replacing, holes in walls and worn out furniture.
● Some areas of the home were not fully clean. For example, pull cords in bathrooms were dirty and not washable.

The failure to properly maintain and clean the premises was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People received their medicines as prescribed.
● The medication room was not appropriate. The locality manager confirmed they had received a quote to provide people with medication cabinets in their own rooms to ensure a more person centred approach to medication administration.
● Staff had received a recent medication competency assessment; however, we were unable to see records of previous competency assessments.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- At the last inspection in 2018 we discussed the refurbishment work needed to the environment with the registered manager. They told us the provider had a plan in place to make improvements where needed. At this inspection we found improvements had not been made.
- Some areas of the home required attention including redecoration. Carpets required replacing as some were stained or not correctly fitted.

The failure to properly maintain the premises was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People could not see out of the windows in lounge dining areas as this had privacy glass in place.
- The building was not fully accessible to people. For example, bathrooms were locked, and staff slept in the communal/lounge dining area during the evening which meant people could not access the lounge/dinning or kitchen area.

Staff support: induction, training, skills and experience

- Staff did not receive supervision and appraisal in line with the provider's policy.
- Staff had received training. However, this had not been effective because staff had been unable to recognise the culture of restrictive practice and people's privacy and dignity not being maintained.
- The provider had not assessed staff competence on how to use PPE safely. Two staff were unable to explain the correct procedures for putting on and taking off PPE.

The failure to provide appropriate, supervision and appraisal was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt supported and that the registered manager was approachable.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People did not always receive their annual health checks. This is a check to support people with a learning disability to find any problems early. The registered manager confirmed they were addressing this.
- People were supported to be weighed. However, one person was not getting weighed regularly due to not

being able to access external scales during the COVID-19 pandemic and no alternatives had been sought.
● People were offered a choice of two meals. However, they were not always given opportunity to be involved in meal preparation.
● People told us the food was nice.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
● Care plans were detailed but these were not always followed in practice to enhance people's choice and skills and to deliver care in line with best practice.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Capacity assessments had been carried out. However, best interests meetings had not been recorded to evidence the decision made and who was involved.
● When restrictions were in place, there was limited evidence these had been reviewed and least restrictive options tried.
● DoLS applications had been submitted were appropriate.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's independence was not encouraged. For example, people who had the ability to make meals were not supported to do so. One person told us, "No I am not allowed to make my own dinner. If want a snack they (staff) do it. I should do it myself really I know how to do things myself."
- People's privacy and dignity was not always maintained. For example, one person was regularly seeking out staff early in the morning with no clothes on and they needed support for incontinence..
- People were not treated with dignity and respect. Whilst we observed some pleasant interactions between care staff and people, the institutionalised approach to care within the service demonstrated a clear lack of respect for people and their life choices.
- People did not always feel they were treated with respect. One person told us, "Staff can be bossy, telling me what to do, I don't like it. They tell me, do this and do that, they're not in charge of me."

The failure to treat people with dignity and respect, and failure to promote people's privacy and independence was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- Care records did not always evidence people had been involved in the development and review of their care plans.
- People's relatives told us, "I am not involved in any decision making, but they inform me if things have changed" and, "The only time I do hear from staff is if [Name] has done something wrong. I am not involved in any decisions about [Name's] care."
- When people required support with decision making advocates were involved.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- People received care that was institutionalised and not person-centred. Staff approach and restrictions in the building limited people's choice and independence.
- Care records contained person-centred detail, however daily notes showed that people did not always received this personalised care.
- Improvements were needed to fully involve people in the development of their care plans.

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 were supported to access the community. However, this was not on a regular basis.
- Activities took place in the service, such as arts, crafts and quizzes.
- A lack of communication with relatives meant that not all people were supported to maintain relationships during the COVID-19 pandemic.

Improving care quality in response to complaints or concerns

- Complaints were not managed in line with the provider's policy.
- Where relatives raised concerns about people's care this was not always recorded. We could not be sure appropriate action had been taken.
- Systems in place to record and monitor complaints were not effective. For example, the complaints log had no complaints recorded but we saw complaints had been submitted by staff.

End of life care and support

- Nobody was receiving end of life care at the time of inspection.
- Staff had not received any training in end of life care but told us they would work in partnership with the appropriate professionals.
- Care plans for end of life care were in place. These required developing further to include more detail about people's preferences and advanced wishes.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had detailed communication care plans.
- Information was available in accessible formats, such as social stories and easy read documents.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There were significant shortfalls in the way the service was being led, which resulted in multiple breaches of regulation. The registered manager did not lead the service in line with best practice, guidance and the law.
- The systems in place had failed to identify the concerns we found at this inspection.
- Monitoring systems were not effective as they had failed to identify the culture of the service and the restrictive practice. Behaviour records and daily notes evidenced a culture of restrictive practice.
- The provider had failed to learn from incidents, previous safeguarding concerns and complaints. For example, concerns regarding the environment and consistent allegations of verbal abuse.
- Records were not always accurate or complete. For example, best interests and complaint records.
- Records were not always easily accessible during the inspection. We requested to see staff's previous competency assessments and the registered manager was unaware were these were. Capacity assessment and best interests' decisions were not always accessible in people's care files.

The failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A new locality manager had been employed at the service and was working towards an action plan and supporting the registered manager. However, not enough improvement had been made at the time of inspection to ensure the provider was meeting legal requirements.
- The locality manager was open, honest and responsive to feedback during the inspection.
- The provider confirmed they will be closing the service and will work in partnership with the local authority to ensure people are appropriately supported through this transition.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Poor, out of date practices were embedded in service delivery. These practices failed to empower people and ensure they receive person-centred care.
- Relatives were not aware of the current visiting procedures at the service. The registered manager informed us they had contacted relatives to discuss this but there was no record of this.

● Staff surveys had been carried out, but they were at organisational level, so the service was unable to use this to learn and develop.
● There was no evidence of relative satisfaction surveys.
● Newsletters were sent out from the provider, but there was no information sent from the service to keep people and their relatives of updated about the service and issues affecting them.

Failure to seek and act on feedback to drive improvements in the quality and safety of the service was additional evidence of the breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff and house meetings were held, and social stories used to promote engagement.
● The locality manager confirmed they were in the process of developing service level newsletters.

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 registered manager had not been open and honest as they had failed to act on safeguarding concerns which meant the appropriate people could not be informed.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People were not fully supported to maintain their independence. 10 (1) (2)(B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse. Systems in place were not effectively established to prevent abuse and ensure concerns were escalated where appropriate. 13 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to maintain the premises and hygiene of the service. 15(1)(a), 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to deploy sufficient numbers of staff. Staff had not received supervision and appraisal in line with the providers policy. 18(1) (2)(a)

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service, They provider had failed to assess monitor and mitigate risks relating to the health and safety of others. The provider had failed to maintain accurate, complete and contemporaneous records. Systems in place did not ensure effective communication with staff and relatives. 17 2 (a)(b)(c)(e)

The enforcement action we took:

We have issued a warning notice