FitzRoy Support

# The Pastures

## Inspection report

1-4 The pastures
Yarmouth Road
Hales
Norfolk
NR14 6AB

Tel: 01508486045
Website: www.efitzroy.org.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Pastures is a residential care home providing care for up to 13 people. There were 12 people living at the service at the time of the inspection. The service accommodates people with a learning disability and autistic people who also have sensory and medical and health care needs. Accommodation is over 3 bungalows which were personalised, and people had the equipment they needed. 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.
Right Support:
Although staffing levels were maintained in line with people's assessed needs and agreed funding levels there was a high staff vacancy which impacted on people's care and support. Not all temporary staff had the same level of training as permanent staff and 30 staff had started in the last year. This meant a lot of staff were inexperienced and did not have a good insight into people's needs. The number of incidents is a good indicator that people experienced distress and had a lack of control over their environment and the staff that supported them.

The model of care did not always support people to make choices and have some control over their daily lives. Most people living at the service were supported by a core team of staff but not all. Staff allocation was completed on the day of the shift and considered the skill mix, training and whether staff were drivers. People could be supported by multiple staff across the day and changes to staffing was not well planned for. This led to frustration as people were not always supported in line with their communication and sensory needs.

We had concerns about the admission process and if this always considered the scope of the service and skill mix of staff. The support needs of people already living at the service were not considered when decisions were made about new people moving into the service.

Records showed a high level of incidents and medicine related incidents which were reducing month on month. However, any incidents could significantly increase the risk of avoidable harm. Oversight of staff practice and people's clinical care was the responsibility of the registered nurse, who was overseeing 3 bungalows and had high numbers of temporary staff to deploy across the shift and provide supervision for.

Staff did not always support people in the least restrictive way possible and in their best interests. Policies and systems were in place but variations in staff and a lack of clear guidance when supporting people new to the service led to variations in care.

Right Care:
We found care was not always person-centred and did not always promote people's rights. During our inspection we identified some good interactions with people, but this was limited to some staff. Staff did not always speak with people on a regular basis to help reduce the risk of social isolation. We also noted some staff were not able to use sign language and were supporting people with sensory impairments and limited communication.

People's needs were clearly documented, kept under review and where changing needs were identified these were followed up with relevant professionals. There were close working relationships with family and the community. Safeguarding concerns were being identified and acted upon as appropriate.

Right Culture:
The provider was not ensuring that the culture of the service always enhanced peoples experiences and safety. Staff received training to enable them to meet people's care needs and training was updated as required. Staff spoken with stated the training provided was of the highest standard, but we found the care and support people received was variable depending on who was supporting them. A number of recent safeguarding concerns had been raised about poor staff conduct. The registered manager was addressing this. There was a lack of person-centred activities and care was not always planned in the right way to meet a person's needs and empower them. A range of audits were completed but did not sufficiently focus on peoples experiences and safety.

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 the service under this provider was good (published on 11 November 2022).

Why we inspected
We received concerns in relation to safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. This inspection was prompted by a review of the information we held about this service. The overall rating for the service has changed from good to inadequate. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Pastures. house on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's safety, staffing, governance, and oversight of the service and person-centred care in line with Right support, right care, right culture. 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

continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

he service was not well led.

Details are in our well led findings below.

# The Pastures

**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.

Inspection team
The inspection was carried out by 3 inspectors which included a member of the medicines team and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service .

Service and service type
The Pastures 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. The Pastures is a care home with 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 18 October 2023 when we visited the service, and we visited the service again on 23 October 2023. We provided formal feedback on 07 November 2023.

What we did before the inspection
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 reviewed information we held about the service. We used all this information to plan our inspection.

During the inspection
We reviewed records including 5 care plans. We reviewed medicine administration and associated records for 10 people and spoke with 2 members of staff about medicines, toured the environment and spoke with the registered manager, the registered nurse on duty, the activities coordinators, 2 deputy managers, 7 staff, the domestic staff and 8 relatives. Observations of people's care and support was our main method of seeking feedback about people's care and support. Following the inspection, we continued to request information to clarify evidence collated, including quality assurance records, staff training etc.

Inadequate

# 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 Inadequate This meant people were not safe and were at risk of avoidable harm.

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

- Risks associated with people's care were clearly documented but actions documented in care plans and risk assessments were not always followed increasing the risk to people from avoidable harm. Suitable deployment of staff was more challenging due to the continued reliance on temporary staff and complex admissions.
- 106 incidents affecting people's health and safety, including staff had been recorded between May and October 2023. Omissions in care included entries where people's personal care had been missed or not provided in a timely way which could compromise their skin integrity and dignity and staff not recognising when a person was experiencing symptoms consistent with them having an epileptic seizure. The provider identified a lack of training as the root cause for this incident and this had been rectified. However, evidence provided to us at the time of the inspection showed a lack of detailed analysis to reduce the likelihood of further incidents. The provider has since assured us monthly key team meetings take place and learning from incidents take place and are shared with staff and other professionals.
- Relatives expressed their confidence in the nursing staff and permanent staff but stated communication was not good and not all staff were sufficiently familiar with their relatives needs which could lead to unsafe practice. For example, staff did not follow one person's correct diet plan which resulted in an increase in self-harm, worsening gastroenteritis. A failure to follow the person care and support plan potentially contributed to a change in their needs.
- Incidents were reviewed at senior level, but we were concerned about repeated incidents occurring at specific times. For example, during changeover of staff which did not consider people's needs for routines and predictability.
- Incidents involving injuries to staff were recorded and strategies were being developed to ensure staff had the necessary training and support to meet people's needs. A lack of clear planning as to how a person's needs should be met on admission continued to put staff and people at risk of unsafe care.
- Upon admission an emergency evacuation plan and other key documents were not in place within a reasonable time frame which meant staff might not be aware of how they should support people safely although robust fire training and drills helped mitigate risk.
- Some people had 1-1 or 2-1 support from staff and we found at times staff and people were all in the kitchen. Previous incidents have shown that when people were in close proximity with each other there was an increased risk of incidents occurring, such as assaults, which placed people at direct risk of harm.
- A number of people currently using the service had legally agreed restraints such as arm splints and gloves to reduce the impact of self-injurious behaviours. Where people were subject to a Deprivation of liberty safeguard (DOLs) and these had been authorised, this information was included.
- Multidisciplinary teams were involved in supporting staff to provide safe care. We found however a new admission to the service had meant there was limited information about how to meet the persons needs

and in their best interest. A lack of documentation meant care could be open to interpretation and distress behaviours could potentially be reduced if a core staff team had been put in place.
●Permanent staff had received training to help them support people at times of distress and but had sometimes relied on restrictive practice which did not uphold the values of person-centred care and human rights.

We were not assured that people always received safe care in line with their assessed needs This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
●60 medicine errors had occurred in the last 6 months which were divided into different categories including medicine recording errors, medicines being out of stock and medicines being administered incorrectly. The root cause of medicine errors was not documented within the incident record and medicine errors put people at risk of avoidable harm.

We were not assured that people always received their medicines safely and this was further evidence of a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicines care plans and risk assessments were due a review which the registered manager confirmed was imminent. Improvements were being made to the auditing processes which was effective in reducing the number of medicines errors.
● Staff responsible for administering medicines completed medicines training and had their competencies assessed at regular intervals.
●Medicines were being kept securely and at correct temperatures and people living at the service received regular reviews of their medicines by prescribers in line with national guidance.

Staffing and recruitment
●The continuity of staffing was a significant factor in ensuring the wellbeing of people using the service. People living at The Pastures had a range of significant needs, including the requirement for nursing input and considerable support around distress behaviours resulting from their sensory and communication needs not being met.
●There were 17 full time staffing vacancies at the time of our inspection and 30 staff (more than half the staff team) had been in post for a year or less. Family members expressed concern about the continuity of care and the lack of knowledge some staff appeared to have. A family member told us: "I used to recognise staff but last weekend I did not recognise anyone." Another family member said, ''It tends to be agency staff at the weekend." This had the potential to impact on people's experience of care as some of the staff teams were still within their probationary period and as such had not been fully assessed as to their suitability to their job role. Equally the use of high numbers of agency staff to fill vacant positions could lead to fragmentation, although the provider told us some agency staff were long term and eventually became part of the permanent staff team.
●People's care and support plans were very detailed but made it clear relationships and continuity were important factors in helping to ensure people had a good day. During the inspection we noted not everyone was supported by staff who worked consistently in line with the service users' needs. A service user newly admitted did not have a core staff team around them which may have ensured a smoother transition and reduced their level of anxiety.

We were not assured that the provider deployed sufficient numbers of suitably qualified, competent, skilled, and experienced staff in line with people's assessed needs. This was a breach of regulation 18 (Staffing) Of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."

●We found however the registered provider had robust recruitment strategies in place which included having a reward programme for staff. They had been able to attract staff through increased pay and more favourable working conditions.
●Recruitment processes were robust to help ensure only suitable staff were employed and records included pre-employment checks such as references and with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse.
●Safeguarding concerns had been previously raised regarding physical restraint which placed people at risk of avoidable harm and did not uphold their human rights. These safeguarding concerns were being addressed with the regular consultation and input from a team of professionals .
●Safeguarding concerns were raised as appropriate and the registered manager was open and transparent in their dealings with the safeguarding team, CQC and other bodies. They were working with other agencies to ensure clear care plans and risk assessments were in place to support staff in the safe delivery of care.
●They were proactive in raising concerns about other health care professionals particularly when people did not receive joined up care when going into hospital.

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).

●The service was not fully working within the principles of the MCA and legal authorisation was not in place for everyone. Restrictive practices were in place to support people who could experience distress. However, in one instance we could not see how this had been agreed it was in their best interest or the least restrictive.
● For most people multiple agencies had been involved in agreeing any restrictive practice considered necessary to reduce the risk of harm to people and in their best interest. For example, the use of splints due to self- injurious behaviours and the use of safe holds were clearly documented and showed regular contact with the safeguarding authorities contacted.
●If needed, appropriate legal authorisations were in place or had been applied for to deprive a person of their liberty. Any conditions related to DOLs authorisations were being met.
●Advocates had been sought when people had no legal representation and lacked the mental capacity to make complex decisions.

Preventing and controlling infection
●There were good infection control procedures in place and the environment was well maintained and clean. Staff observed good hygiene practices and received training and updates on infection control and

government guidelines.

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 our last inspection we rated this key question Good. At this inspection, the rating has changed 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.

- The provider was not working in line with legislation to ensure the service was appropriate to meet the needs of each individual and in line with their assessed needs.
- Unplanned admissions created an unsafe situation for the person being supported and did not consider the wider needs of people already using the service. It also placed staff at risk because they were unfamiliar with the persons needs and were trying to support them at times of distress.
- The provider considered through ongoing assessment whether peoples' needs could be met within the service. Further consideration was needed to consider how people's experiences matched current guidance right care, right culture right support and how people were supported with ordinary life principles.
- Risks associated with high staff vacancies, and the use of new and, or temporary staff had not been fully considered when taking new admissions to the service. On admission to the service limited information was available about a person's needs, and people were not always supported by a core team to help them settle in and build up trusting relationships with staff. Not all temporary staff had completed positive behavioural support or had sufficient understanding of people's non-verbal communication needs. This could potentially lead to people not having their needs met.
- Admissions to the service needed to be considered carefully in relation to the existing staffing level vacancies and their level of training, experience, and skills necessary to meet people's needs safely. Consideration to the needs of other people using the service should also be a consideration when planning the service.

Continuous learning and improving care.

- People had no real influence over their care and support. The provider's quality assurance system had not been effectively adapted to enable people to contribute and express what improvements they would like to see.
- The provider had a 'resident satisfaction survey' which did not fully consider people's experiences as it had not been adapted to make it 'user friendly.' The provider said they planned to introduce documentation in easy read and braille. Digital technology had been considered but was not in place to measure people's experience of the service as part of the provider overarching quality assurance system.
- Family members spoken with told us that communication across the service had improved but they had less awareness of what was happening at provider level. A 2023 survey had yet to be completed but was due to be introduced in 2024 and be more accessible

This was a failure to effectively assess, monitor and mitigate the risks relating to people's health, safety, and welfare. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people.

- We were not assured that the provider was ensuring that the culture of the service always enhanced peoples experiences and safety. Right support, right care, right culture is the framework in which services supporting autistic people and people with learning and physical disabilities are assessed against. It focuses on upholding people's human rights, choices, and access.
- The service supported people with a wide range of needs including those requiring nursing care and palliative needs and others who had complex communication, sensory and behavioural needs. Not all staff had the necessary level of skill and experience to meet such a range of complex needs, and this could result in fragmented care. The provider needed to consider staffing levels and skill set as part of the current admission process
- People were supported by the number of staff identified as necessary, but we found examples of variable staff practice. For example, during 'group activity' some staff were disengaged and not supporting people appropriately to participate in activities.
- Communication between staff and people using the service was not effective and staff were observed not always following people's communication and sensory plans. Language used by staff was mostly spoken and sentences were too complex and did not consider people's sensory processing needs.
- During care interactions multiple staff were sometimes required to support individuals which could be inappropriate and demonstrated a lack of effective planning to ensure people's needs were met in the most person-centred way as possible.
- Most people had high levels of staff support for their social and physical needs. Whilst we recognised activity schedules provided a structure to people's day, we observed some limitations. Transport on site was restricted which meant some trips had to be planned in advance. Activity schedules were not always individualised with a number of 'group activities' which people might not benefit from due to their sensory needs and anxieties. We saw for example a person with 2 to 1 support had 3 activities scheduled for that day which did not include evening activity and there was a lot of repetition.

We were not assured that people always received care and support in line with their preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others

- Systems were in place to review people's daily care. Families were mostly supportive of the service but felt communication could be improved. A health care professional also expressed concern about communication when certain core staff were off, or temporary staff were covering.
- One family spoke positively of their relative's transition and how well they were supported after a previously traumatic experience. Families told us they could be involved, and the activities coordinator sent photographs showing the different activities which had taken place including celebrations of key events like Halloween.
- Families spoke of positive relationships with 1 saying, "I think it's a brilliant home, they have so much patience."

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 was aware of informing CQC, the local authority and relatives of any incident affecting the wellbeing and safety of people using the service. They were open, transparent, and quick to deal with things.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive care and support which met their needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People did not always receive safe care in line with their assessed needs. Some staff were not adequately trained or experienced to provide safe care |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing levels were maintained but we were not ensured staff were always suitably deployed or had sufficient experience to meet service users needs. |