Residential Care Services Limited

Franklyn Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Franklyn Lodge is a care home which provides accommodation and personal care for a maximum of nine adults who have autism and learning disabilities. At the time of this inspection, there were nine people using the service.

The service had been developed taking into account best practice guidance and the principles and values underpinning Registering the Right Support (RRS). The service had mitigated against environmental factors that would otherwise make the environment feel institutional. For example, there were deliberately no identifying signs, intercom, cameras or anything else outside to indicate it was a care home.

People's experience of using this service and what we found
Quality assurance systems had not been used effectively to identify concerns we identified during this inspection. We found no evidence people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. Mainly, we found the culture at the service did not promote person centred care. This was evident across all areas where we identified shortfalls.

The service did not apply the full range of the principles and values of RRS and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of RRS for the following reasons. We found people followed a set of generic routines, which was not consistent with person centred care.

People were not always protected from potential harm. Risk assessments for people with behaviours that challenged the service did not follow positive behaviour support approaches. PBS is a person-centred approach, recommended to support people with learning disabilities who display behaviours that challenge. The risk assessments did not identify specific factors that contributed to people's behaviours. There was a risk that staff could miss specific triggers and would not be able to support the person fully to minimise the likelihood of the behaviour happening in the first instance.

Staff were not deployed effectively. From the records reviewed, it was not clear how many staff were scheduled to work per shift. We noted irregularities as staff who were rostered to work, were not the same as those completing the handover records on the specified dates. The irregularities in deployment of staff meant we could not be assured that people's needs were being sufficiently met.

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 26 June 2019).

Why we inspected
We received concerns in relation to staffing, quality of risk assessments and person centred care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Franklyn Lodge

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.

Inspection team
The inspection team consisted of one inspector.

Service and service type
Franklyn Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 and took place on 27 February and 6 March 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service.

During the inspection
We were not able to speak with people using the service because they had complex needs and were not able to share their experiences of using the service with us. We gathered evidence of people's experiences of the service by reviewing their care records and observing care. We reviewed a range of records. This included four people's care records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risk assessments for people who displayed behaviours that challenged did not provide enough details to minimise risk.
- We found risk assessments of people who displayed behaviours that challenged the service were not consistent with positive behaviour support (PBS) approaches. A PBS is the recommended approach to support people with learning disabilities who display behaviours that challenge. The ABC (antecedent, behaviour and consequence) forms had not been completed as part of an assessment to understand the factors that contributed to people's behaviours. This was important to enable the service to develop strategies that reduced behaviours that challenged, and therefore enhance people's wellbeing.
- For example, one person was identified to display behaviours that challenged the service and was therefore at risk to themselves and others. However, their risk assessment did not identify factors that contributed to the behaviour that challenged nor did it outline measures to reduce the likelihood of the behaviour happening, including managing situations that could trigger the behaviour. Therefore, there was a risk that staff could miss specific triggers and would not be able to support the person fully to minimise the likelihood of the behaviour happening in the first instance. We found this to be a recurring shortfall in relevant risk assessments we reviewed.
- Care plans and risk assessments were reviewed every six months or more as necessary. However, we found these reviews to be of limited scope. All reviews followed the same format and mostly repeated previous conclusions. For example, one person's care plan and risk assessment concluded, "I have reviewed all aspects of [the person's] care and risk assessments. There are no changes." The same conclusion was reached in all the other three consecutive reviews carried out thereafter. This was despite people's risk assessments and care plans having initially identified short- and long-term goals. No reference of this was made in the reviews. Therefore, we could not be assured the care plans and risk assessments remained relevant and useful.

Staffing and recruitment

- Staff were not deployed effectively. From the records reviewed, it was not clear how many staff were scheduled to work per shift. Staff were assigned to a fixed shift work pattern, which meant they worked the same days and hours each week.
- However, when we reviewed the rota and handover sheets, we noted irregularities as some staff who were rostered to work were not the same as those completing the handover records on the specified dates. Furthermore, some staff members who signed in were not the same as those listed on the rota. Therefore, it was unclear, which staff were working on particular days and whether they were sufficient to meet people's needs.

● There were examples, which showed the rota did not reflect the actual attendance of staff. We noted from a handover sheet, two members of staff did not attend for rostered morning shifts (7am-10am) on 27 February 2020. A staff member on duty told us, "[This member of staff] was not in today. [They] probably phoned in sick", and, "[The other member of staff] was not in today. I am guessing [they] may have phoned in sick as well."
● The service relied heavily on agency staff. Out of 14 support workers, 12 were agency staff. The agency staff were used to fill regular and scheduled demand. We could not determine the effect of this on the quality of care. However, it was clear there were communication gaps. For example, some hospital appointments had been cancelled, but there was no record to explain why these appointments had been cancelled. We saw that one person had an appointment on 21 January 2020, but this had been cancelled and rescheduled. Another person's dental appointment had also been cancelled. In both examples, there was no information in relevant documents that gave a reason for the cancellations. There was a risk of a breakdown of continuity of care if information was not communicated effectively between staff.

Using medicines safely
● People received their regular medicines as prescribed. However, we identified shortfalls in the management of PRN (as and when required) medicines.
● Although PRN protocols were in place. These were generic and not person-centred. They did not contain enough information to support staff to administer PRN medicines as intended by the prescriber. The registered manager told us the PRN protocols would be updated.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. The above is evidence of a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There were safe recruitment procedures. Records showed that pre-employment checks had been carried out. The Disclosure and Barring Service checks (DBS) had been undertaken prior to staff commencing work. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with people receiving care.

Learning lessons when things go wrong
●There was a record of accidents and incidents, including lessons learnt. Records showed staff had been provided with guidance to prevent re-occurrences.
●The service had responded to a London Fire Brigade enforcement notice. All failures in the notice had been remedied to satisfaction. This meant the environment was safe for people using the service.
●Each person had a personal emergency evacuation plan (PEEP). This gave guidance to staff to ensure people's safety was protected during the evacuation of the home in the event of fire or other emergencies.

Systems and processes to safeguard people from the risk of abuse
● People who used the service were protected from the risk of harm and abuse. A safeguarding policy was in place.
● Staff had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. They were aware they could notify the local authority, the Care Quality Commission and the police when needed.

Preventing and controlling infection
● The home was mostly clean and there were no unpleasant odours. There was an infection control policy

in place and staff had completed relevant training. They wore personal protective equipment (PPE) such as gloves and aprons where required.

● At the time of the inspection covid-19 was an emerging pandemic. National policies had not yet been amended. However, the service had started raising awareness regarding handwashing. There were posters displayed around the home.

Requires Improvement

Is the service well-led?

Our findings

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

At 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 service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- There were formal systems for auditing relevant areas of the service including, care records, health and safety, activities, control and medicines management. However, the shortfalls in quality of risk assessments, reviews and lack of personalisation in care had not been identified prior to our inspection.
- Staff were clear about their roles and management structures in place. They were aware of their responsibilities and the reporting structures in place. However, there were limited systems to facilitate effective communication with management. Principally, staff were not always aware of the whereabouts of managers.
- We noted managers were shown as working on site, however this was not the case when we undertook day one of the inspection. The registered manager and the deputy manager were not on site for a rostered mid shift (10am to 4pm, and 9am to 4pm) respectively. There were no further details about their whereabouts. A member of staff told us, "Probably she [registered manager] has a meeting. I don't know where she is." and "She [deputy manager] is at another unit. I am not sure which unit. I am not sure whether she is having a meeting or working there." We terminated the inspection prematurely on the first day because there was no manager on site to give us access to relevant documents. The managers were aware of our presence when we arrived.
- Therefore, we could not be assured the leaders of the service were visible and were readily available when needed.

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

- The culture at the service did not promote person centred care.
- We found people followed a set of generic routines. Records showed people woke up between 5:30am and 6:30am each day. All the care plans we reviewed contained largely similar information for each person relating to specific routines.
- We looked at how people were supported with their personal care. There was a generic plan across all the files reviewed. For example, they all stated, "When the 7am shift starts, a female staff is allocated to me to support me with my personal care." This was confirmed by a member of staff who told us, "We start to wake up everyone early and by 8am everyone is ready." It was not clear how these routines came to be. However, there were no major variations of how people preferred to be supported. This was not consistent with person centred care.

● The rotas may not have been tailored to people's real choices and preferences. Shift patterns were fixed and aligned to generic routines. It was not clear if the set routines also encouraged a preference for agency staff. For example, most people attended a day centre, college or other community activities from 10am to 3pm, Monday to Friday, which meant having permanent staff would have entailed wasted capacity during these hours. Whilst this may have been a preferred model of working, we were not assured this was focussed around people's preferences.
● Daily notes and handover sheets lacked personalisation. For example, one handover sheet read, "All service users woke up well after a good night's sleep. They were all supported with personal care. They all had breakfast of their choice. They are now in the lounge, waiting for the bus." This did not demonstrate person centred care.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 understood their responsibilities in relation with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We had been notified of notifiable events.

Working in partnership with others; engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service worked with other health and social care professionals which ensured advice and support could be accessed as required. We could see evidence of this in records, including appointments with relevant professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were robust enough to demonstrate safety was effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had not been used effectively to identify concerns.