Life Opportunities Trust

Firs and Hewlitt

Inspection report

The Firs and Hewlitt
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Firs and Hewlitt is a care home providing accommodation in two buildings for up to 13 people with a learning disability or autism, including older people, some of whom are living with dementia and/or a physical disability. At the time of inspection, nine people were being supported.

People's experience of using this service and what we found
There were not enough staff available to meet people's needs in a timely manner. Staff told us people were often left alone in the communal areas, with no staff support for significant periods of time. Not all staff had completed training relevant to their role to safely support people's individual needs. The service had a high reliance upon using agency staff to provide support to people.

Risk assessments were either not in place or did not provide staff with appropriately detailed management plans. Behaviour management plans were not always sufficiently detailed or current. This meant staff had limited guidance as to how to safely support people to live meaningful lives. The provider had not considered how they could positively manage risks to enhance people's independence and quality of life.

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 able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People's choice, control and independence were not maximised, and care did not always promote people's dignity and human rights. The values and attitudes of the provider did not ensure people were able to lead empowered lives.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

There was not a formal process for learning lessons and improving the quality of care people received. Incidents that meant people may be at risk of harm were not always reviewed robustly.

We observed extensive cracks within one of the properties walls. The registered manager told us that this had been ongoing for two years. The provider had raised this issue with the landlord but had not considered the impact of the people living there.

The provider failed to operate a robust quality assurance process to continually understand the quality of

the service and ensure any shortfalls were addressed. Service level audits had not been completed as required. Incidents had been reported to the registered manager, however, these were not reviewed to identify emerging themes or trends. Staff gave varying feedback about the management of the service.

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 28 March 2019).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service, in relation to people's safety and welfare. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the overall provider oversight at the service, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 coronavirus and other infection outbreaks effectively.

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

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

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

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 staffing, risk management and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for 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.

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?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Firs and Hewlitt

Detailed findings

Background to this inspection

The inspection
This was a focused inspection to check on a specific concern we had about people's safety and welfare. 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
The inspection was completed by two inspectors.

Service and service type
Firs and Hewlitt 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 the inspection
We reviewed information we had received about the service since the last 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 two people who used the service and observed interactions between people and staff. We spoke with six members of staff, the registered manager and an area manager. We also contacted the local

authority and safeguarding team for their feedback.

We reviewed a range of records. This included care plans, risk assessments, activity records, daily notes and medicines records. A variety of records relating to the management of the service, including training and quality assurance documentation was 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 as requires improvement. At this inspection this key question has remained the same. 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.

Staffing and recruitment
At our last inspection we recommended the registered provider ensured that staff levels were such that people's social and care needs were met at all times. The provider had made no improvements and the situation had deteriorated at this inspection.

● Staff told us there were not enough staff to meet people's needs. One staff member said, "There is not enough [staff] presently, there has been a lot of struggles with just having the two staff on shift. They [people] then have to wait until we are less busy. It means they then get upset and impatient and call out for us to help. We have had to leave them unclean, sometimes for an hour. It depends on who is available." This meant people were at risk of not having their needs met in a timely manner.
● A second staff member said, "Two staff is not enough. Sometimes we have to get them showered, get them breakfast, help send them off to the day service, the workload means we do not do our best. If two staff are washing and showering, then nobody is free to support other people. So, from 05:30 when people wake up, they will be helped to wash and dress but then will maybe be on their own until 09:30 maybe 10. It's hard and upsetting for them." This meant staff had limited time to support people with other activities and aid their emotional wellbeing. During the inspection we observed people left for periods of time with no interaction from staff. Throughout the day, one person asked staff how they were doing and would get a 'thumbs up' in response. Little attempt was made to engage this person in meaningful conversation or activity.
● The provider had recently reviewed and amended staffing levels within the home. We were told, in Hewlitt a support worker had been replaced with a staff member who provided one to one activity, but not assistance with personal care. When we asked why this was changed and the rationale, we were told by the registered manager that it was the provider who made the change. One staff member told us, "We used to be three but now we are two. One to one is not on the floor. All one to one is to do, is be with the service user they are working with. Sometimes the 1:1 will help us out, but they are not here to get them washed or dressed."
● People were not supported by a consistent, sufficiently skilled and experienced, staff team. One person had complex needs which meant they required 1:1 support at all times and would become distressed if supported by unfamiliar people. On the day of inspection, this person was supported at hourly intervals by different staff, including an agency member of staff and a new member of staff on their first week at the home. One staff member told us, "We wouldn't normally have someone new supporting [name] but we are so short staffed, they have had to step in. They are managing but they haven't had a proper induction." When we spoke with this member of staff they told us they had received no induction or guidance in how to support this person but to "come and get someone if there were any issues." This meant people were at risk

of receiving care that was unsafe and not in line with their needs and preferences.
● We referred our concerns to the local authority who reviewed staffing levels in the home. Immediately following our inspection staffing levels in the service were increased.

Assessing risk, safety monitoring and management
● Risk assessments were either not in place or did not provide staff with appropriately detailed management plans. The registered manager explained that staff were in the process of reviewing both care plans and risk assessments.
● Behaviour management plans were not always sufficiently detailed or current. During the inspection we observed no meaningful engagement with one person, who had complex needs. One staff member told us, "We have tried different things to engage [person] but we need more support. We can only work with the guidance we are given. I'd love to take [name] out and do different activities." Staff told us there had been some professional input to support this person. However, when we checked the person's file, most of this was historic and where suggestions had been made, there was no evidence these had been implemented in a planned manner, sustained or reviewed. Hourly observation notes indicated that this person only exited their room once or twice a day, for short periods of time. The provider had not considered the impact of this isolation on the person or how they could provide them with adequate stimulation. They had also not considered how they could positively manage risks to enhance this person's independence and quality of life.
● Not all staff had completed training relevant to their role to safely support people's individual needs. Training records showed only 33 percent of staff had completed a course/session on learning disability, which was the same for epilepsy training. One staff member had completed privacy and dignity training, but no staff had completed training in dysphagia or managing continence needs. These were all training courses relevant to the needs of the people living at Firs and Hewlitt. One staff member told us, "There is a lot less support for staff now. I learnt a lot on my induction, it used to be a really detailed training pack. Now there is barely any induction provided." Another member of staff told us, "I'm not surprised about [recent medicines errors], we are not trained properly."
● The service had a high reliance upon using agency staff to provide support to people. The training provided to these staff was basic and covered none of the key areas to provide these staff with the specific knowledge and skills required. One staff member when asked how they support a person who became distressed said, "I don't really know their diagnosis, they sometimes scream, they scream just because it is their way of talking. When they scream, we go in and support them." This approach did not demonstrate that staff were suitably trained to understand and support people's needs.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to ensure staff were suitably qualified, competent, skilled and experienced. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We referred our concerns to the local authority and local safeguarding team who attended the home following our inspection, to ensure people's safety and wellbeing.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● A formal process for learning lessons and improving the quality of care people received was not in place. Where incidents occurred, staff received a memo from either the registered manager or provider instructing

them of the improvement required, rather than seeking staff views, or enabling them to reflect on their practice to improve. This meant there was not a process in place to review incidents and mitigate the risk of them recurring.

● Between February and May 2021, nine incidents were reported to the registered manager. Of these five related to medicines errors, where medicines were not given as prescribed or where there was some other error. Records showed that the incident was reported, but the registered manager considered only whether staff were competent in administering medicines and not how to mitigate recurrence. We saw on 02 May 2021; four people were taken to hospital due to a medicines error, for blood tests and observations. This had been reported to the local safeguarding team and was being investigated at the time of inspection.

● Incidents that meant people may be at risk of harm were not always reviewed robustly. For example, one incident reported staff at handover heard a person crying and they were restless. When they checked on them after their meeting, they found the person had scratches to their forehead and neck. Staff reported the concern, however the registered manager, in their investigation, dismissed the wounds and focused their investigation on why an incident report had not been completed.

● Staff knew what abuse might look like and knew how to raise and report concerns.

Preventing and controlling infection

At our last inspection we recommended the provider ensures the premises in which people live was of a suitable decorative standard. We saw no evidence of improvement at this inspection.

● We observed extensive cracks within one of the properties. The registered manager told us this had been ongoing for two years. The provider had raised this issue with the landlord but had not considered the impact of the people living there. Staff told us one person was unhappy with the large crack within their bedroom and it was causing them to become anxious and unsettled. It was only once we raised this with the management team on the day of inspection, that they considered moving this person into an empty bedroom. Following our inspection, surveyors attended the property to assess the damage to remedy any immediate structural issues.

● The buildings were tired and showing signs of significant wear and tear, with flaking paintwork and some windows in need of repair. We observed staff to be cleaning high touch points throughout the day and there were no unpleasant aromas.

● Staff ensured the risks in relation to COVID-19 were managed appropriately, by wearing the correct Personal Protective Equipment (PPE), such as gloves, aprons and masks. Procedures were in place to ensure visitors to the service completed a health declaration and temperatures were taken. Hand sanitiser and PPE was available. Staff told us they tried to maintain social distancing wherever possible. Regular testing was in place and people and staff had been offered the COVID-19 vaccine.

Using medicines safely

● Medicines prescribed on an 'As needed' [PRN] basis had a care plan in place. However, this guidance lacked information around how people would communicate they were in discomfort, or how to monitor people.

● Medicine administration records (MAR) were in place and people's medicines had been administered as prescribed, since a recent incident where four people were taken to hospital, following a medication error. Improvements have been made to the medication administration following this incident.

● Daily checks of the temperature where medicines were stored were not completed. This meant there was a risk that medicines were stored above the optimal safe temperature range.

● Medicines were administered by trained staff who were observed during the inspection to be administering medicines safely. We checked a random sample of medicines and the stock count was found to be correct, with no gaps on the MAR.

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; 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 provider had failed to ensure the quality of care was monitored. They had failed to ensure a system of governance was in place following recent inspections of two other locations which identified the same concerns. This demonstrated to us that the culture of the organisation was not about continuous learning and improving care and left people at risk of receiving poor standards of care.
- The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. We asked the registered manager for a copy of the audits carried out by the provider. They told us these had not been completed. We also asked for a copy of the service development plan which would identify areas for improvement. We were told this had not been completed.
- The local authority had carried out a review of the service three weeks prior to our inspection. This review identified 36 separate actions for improvement. These actions related to areas around risk management, health and safety and ensuring care records were accurate. The registered manager or provider had not incorporated these actions into a service improvement plan or shared the findings with staff to improve practice.
- Service level audits had not been completed. Weekly checks of fire safety and hot water daily had been completed. However other areas had not been completed. For example, the last infection control audit and assessment of staff competency was completed in January 2021. We asked for audits of areas such as care planning and risk assessments relating to people's care and were told this had not been completed.
- Incidents had been reported to the registered manager, however, these were not reviewed to identify emerging themes or trends. This would enable the registered manager to identify potential areas for improvement.
- Notifications were not always submitted to CQC as required. For example, an investigation requested by the local authority safeguarding team in March had not been notified to CQC..
- Staffing levels were not sufficient to ensure people were supported in a person-centred manner. The registered manager told us they did not know the staffing hours they were required to provide. They told us the provider amended the staffing structure in the home removing a support worker and replacing them with a staff member who provided just one to one activity. An assessment of dependency had not been carried out, and we found this impacted negatively on people's quality of life.

The failure to ensure effective governance was in place, to mitigate the risks of unsafe care, 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff gave varying feedback about the management of the service. Some staff felt supported by the registered manager and told us they were able to approach them for help when needed. One staff member said, "The new (registered) manager is okay, she talks to me and is around when I need help and I have had no problems and find them supportive when I need something." However, other staff said they did not feel supported by the provider or registered manager. They told us when they raised concerns these were not listened to or responded to.
- Staff told us the culture and morale in the service was not positive or team focused. One staff member said, "The atmosphere here has been difficult, there is a lot of stuff going on and a lot of blame but not much fixing things or working as a team. Of course, if we are feeling low and stressed it does have an impact of them [people]."
- We asked the registered manager for the outcome of surveys for staff, relatives, people and stakeholders. They were unable to show us the results from this or any actions that demonstrated they responded to feedback.

Working in partnership with others

- Staff made referrals to external healthcare professionals when required.

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 The provider had failed to robustly assess the risks relating to the health safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance was not in place, to identify and mitigate the risks of unsafe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were suitably qualified, competent, skilled and experienced.