Independence Matters C.I.C.

Faro Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Faro Lodge is a care home providing respite care for up to six people who have a learning disability. On the day of our inspection, one person was at the service.

People's experience of using this service and what we found
Risk assessments were not always in place. One person's care plan described risks of leaving the service without staff knowing. No detailed risk assessments had been created to mitigate risk. This person had left the service unsupported during their stay. This placed them in danger.

The provider supported many people who used the service for short stays, periodically throughout the year. The provider had not assessed the mental capacity of any person using the service and had instead completed a Best Interest Decision and Deprivation of Liberty authorisation request. This is not in line with the principles of the Mental Capacity Act 2005.
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.

Communication between the staff and the person supported on the day of the inspection was positive and the person appeared well engaged. Care plans lacked sufficient detail on how to communicate with people, causing a risk that the support may not be consistent.

At this inspection we found the same areas we had highlighted in our previous inspection, evidencing a lack of progress had been made following our last inspection. In addition, other areas appear to of now deteriorated and additional breaches of regulation have now been identified.

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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The last rating for this service was requires improvement (published 13 March 2020).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This inspection was prompted in part due to concerns received about a person leaving the service unsupported. A decision was made for us to complete a comprehensive inspection following this.
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 people being kept safe when being supported, people's mental capacity being assessed and the provider's response to previous inspections that have not enabled lessons to be learnt within 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.

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 effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Faro 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
This inspection was completed by one inspector.

Service and service type
Faro Lodge 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
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection-
We spoke with five relatives of people who use the service about the experience of the care provided. We spoke with seven members of staff, including the registered manager and operations manager.

We reviewed a range of records. This included care records for five people and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional involved with the service.

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 now 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.

Assessing risk, safety monitoring and management

• Detailed risk assessments were not in place to manage risks present within people's lives. For example, we saw one person's care plan documented they were at risk of leaving the service unsupported. There were not any detailed and suitable risk assessments in place to document how staff should manage and mitigate these risks. This resulted in this person leaving the service unsupported by staff during their stay putting them at high risk of potential harm.

• Another person using the service did not have sufficient detail within their care plan. A care plan was in place detailing how to support this person with their nutritional intake, however an assessment from a Speech and Language Therapist (SALT) gave conflicting information. This posed a risk that the individual would be supported in an unsafe manner. The service contacted the SALT to gain further clarification on this persons support needs.

• Guidance on welfare checks were not documented in care plans reviewed for those at risk of leaving the service unsupported, epilepsy or other health conditions that required regular monitoring. Staff spoken too said they, "Were unsure if they were meant to check on people every 30 minutes or 60 minutes". This could result in people not being supported in a timely way in an emergency situation.

• Missing person profiles reviewed did not detail all information about the person. One reviewed did not have a photograph of the person who was at risk of leaving the service unsupported, another did not state that an individual was nil by mouth, where this had been assessed as correct within the person's support plan, another person had no missing person profile in their file at all. These all presented a risk that in an emergency situation this documentation could not be utilised to keep the person safe.

Learning lessons when things go wrong

• At our previous inspection we highlighted concerns with risk assessments and care plans not being in sufficient detail to safely support people, including those at risk of leaving the service unsupported. A person had left the service without staff being aware following our last inspection and their care plan had identified this risk but no steps taken to protect this person from potential harm.

This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the incident where a person left the service unsupported, window restrictors and temporary door alarms had been fitted. An internal process was being conducted to identify lessons that could be

learnt for the future.
• A expanded assessment tool had now been introduced to ensure all risks are being picked up during the welfare calls with people prior to their admission. To identify any change in need and to highlight any precautions that need to be taken by the provider.

Using medicines safely
• There was no medication crusher for a person who required it. A person required their medication crushed prior to being administered. There was no tablet crusher in-situ in the service, the inspector identified this and ensured one was purchased. Staff confirmed that they had used a spoon to crush the medication prior administration. This was not best practice and could cause risks of cross contamination of medication administered.
• PRN [As and when required medicine] protocols were not in place for medications prescribed that way. One person who required use of a nebuliser due to their health conditions had no protocol in place for the use of this medication. This could impact on this person receiving this medication as prescribed.
• Medication training had been completed for staff via e-learning but physical observations of practice had not been completed for all staff. Future dates for practice observations had been booked during the inspection.
• Required documentation had been sought where a person required their medication in an adapted from. The person's GP had been contacted and authorised this method as safe to alter. E.g crushing medicines.
• Stock levels of medication were correct for the person being supported at the time of the inspection. Medication had been correctly signed in and administrations had been correctly recorded. Daily counts had been recorded after each administration.

Systems and processes to safeguard people from the risk of abuse
• Staff had completed safeguarding e-learning to ensure they had the knowledge and competency to safely support people and highlight any concerns with the support offered.
• Staff were able to explain types and symptoms of abuse and confirmed they would report to their line manager or the local safeguarding team if required.
• Incident forms completed were logged on a digital system. This system was then monitored and reviewed for all submissions by the registered manager and quality assurance business partner. This ensured that all appropriate steps were taken after an incident form was uploaded and the relevant people were informed.

Staffing and recruitment
• Enhanced criminal record checks were completed prior to a staff member supporting people. These were reviewed on a yearly basis to ensure they remained valid.
• References were available for the personnel files viewed. The most recent employer had been contacted
• Sufficient staff were deployed on the day of the inspection. Staff told us they have enough staff to support the people safely and ensure their needs are met.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
• We have also signposted the provider to resources to develop their approach.

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 requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

At our last two inspections we found assessments had not been made to determine if formal DoLS applications were needed to be made. At this inspection, we found this area of assessment and documentation was not sufficient. Best Interest meetings and DoLs applications had been completed and were available in the care plans viewed, however there was no record of the capacity being assessed in the first instance. This presented a risk that people may be being restricted where they have the capacity to make this decision for themselves.

We found no evidence that people's capacity had been assessed. This placed people at risk that not all restrictions being placed on them were appropriate. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The operations manager confirmed that a new mental capacity assessment will be introduced to ensure that capacity assessment is fully captured.
• The registered manager told us that all people supported have an emergency DoLs application completed prior to them being admitted to the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

• The registered manager told us that they support people with different beliefs. One person supported spiritual beliefs mean they do not use alcohol. Due to this the service ensure alcohol free hand gel is used when supporting this individual.
• Another person has a specific diet due to their spiritual beliefs; the service ensures they purchase appropriate foods when this person is supported to ensure this choice is respected and upheld.

Staff support: induction, training, skills and experience
• Gaps were identified on the services training matrix as part of this inspection. The operations manager explained that due to Covid-19 some training sessions had not been completed. This resulted in some required training not being completed covering practical percutaneous endoscopic gastrostomy (PEG) feeding tubes. PEG tubes allow fluids and/or medications to be put directly into the stomach, for those who cannot intake food and fluid orally. The lack of staff competency checks placed them and the person at risk as this was part of the care plan written by the provider.
• Shortfalls relating to processes taken when assessing a person's mental capacity and safe administration of medication have been identified through the inspection. Staff have received training in these areas suggesting the training had not been effective to ensure staff worked in a appropriate way.

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans gave conflicting information on how to support an individual with their nutritional intake. A SALT assessment detailed different information to that of the care plan. The operations manager said they would explore this to ensure the information was consistent within the care plan.
• Staff confirmed they offer choice to people regarding their food and drink. Confirming they would monitor people's intake and if people's appetite reduced, they would raise this with their manager.

Staff working with other agencies to provide consistent, effective, timely care
• The service ensured a district nurse would visit when an individual required regular injections during their stay. A family member told us, "The service always contact the district nurses to make sure [person] gets their [medicine]".
• The registered manager told us they have worked alongside other providers to support people into their permanent settings following respite support.

Adapting service, design, decoration to meet people's needs
• People who currently use the service do so for a short period of time but were able to personalise their rooms with their own items as required.
• The service has developed a sensory room which can be used by all people. Offering people sensory stimulation in a variety of methods.

Supporting people to live healthier lives, access healthcare services and support
• The registered manager confirmed that appropriate healthcare professionals were sought when required.

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.

Supporting people to express their views and be involved in making decisions about their care
• Capacity assessments for the people being supported had not been completed. This has not ensured that all people supported are given maximum choice and control in relation to their support levels and decision making.
• Staff told us that one person was able to make choices by pointing at different options. An appropriate choice would be given to the individual to allow them to indicate their preference. This person's care plan required further expanding to ensure this level of support would be consistent across all staff members for a variety of decisions.
• A keyworker system is in place for those people who are attending the service. This ensured a nominated staff member took a lead role in a person's care, ensuring the person was happy and gaining their feedback as much as possible. The registered manager confirmed that due to Covid-19 there had not been any reviews with the people and family members, however these were planned to commence again.

Ensuring people are well treated and supported; respecting equality and diversity
• People appeared to enjoy accessing the service. Staff appeared to engage positively with the person supported on the day of the inspection.
• Staff supported people in a respectful manner. Allowing the person to make their own choice known in their preferred communication method and supporting them appropriately.

Respecting and promoting people's privacy, dignity and independence
• People's privacy and dignity were respected by staff. Staff told us they ensure curtains and doors are closed before supporting a person with personal care to maintain their dignity.
• During the inspection, we observed staff interact with people in a respectful manner. Information about the people was protected and kept securely, and the service complied with the data protection act.

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

• Care plans did not evidence people's capacity had been assessed or that they were involved in planning their support. This caused potential risk that the person's choices would not be taken into account.
• Staff supported people in a personalised way. Staff were observed allowing the person the opportunity to make their choice and following the individual's actions to allow them to advocate for themselves.
• The registered manager told us that there plans for the future were to imbed more structured activities. Allowing people who wished to improve their daily living skills this opportunity.

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.

• We saw examples of pictorial formats within the environment, and peoples preferred communication styles were documented in care plans, which included the use of facial expression and body language.
• Care plans reviewed were documented in the same format. This would make it difficult for some people to have input or an awareness that this document related to them or that it was in place.

Improving care quality in response to complaints or concerns

• The provider had a complaints procedure in place. Family members spoken to all told us they were happy to raise concerns if required and felt comfortable approaching the relevant team member or management.

End of life care and support

• The service was not currently supporting anyone on end of life support. The registered manager confirmed if they were too this would be clearly indicated within the persons support plan.

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 requires improvement. At this inspection this key question has remained the same. 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
• Internal audits had taken place but had not highlighted all areas of concern identified in this report. Care plan training sessions had been completed prior to the inspection however care plans reviewed were not fully complete.
• The provider had failed to ensure capacity assessments had been completed for all people using the service to ensure they were given maximum choice in relation to their support.
• Appropriate and timely action had not been taken as a result of our last inspection at this service, and some of the same areas highlighted still require improvement.
• At our previous inspection we highlighted that individuals at risk of leaving the service unsupported had not been fully risk assessed, following this we found care plans and practices had not been fully expanded to mitigate this risk. Due to practices not evolving a person has since left the service without staff being aware placing them at risk of harm.
• Daily records completed did not give a clear picture of a person's day. One individual was observed to be supported in the sensory room. This information was not recorded within their daily records and only a brief overview was recorded, causing a potential for a true reflection of this persons day not being captured.
• This is the second continuous inspection where we have found the domain of Well Led not Good. Causing concerns on the providers ability to have overall governance of the service.

We found evidence that a person had left the service unsupported, causing distress to this person. Care plans and risk assessments were not robust enough to mitigate risk, and was highlighted at a previous inspection. This placed people in danger. 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
• The managers we spoke with were open and honest, and acknowledged that development was still required at this service. Managers spoken with had a good understanding of the people supported and were passionate about making further improvements to the service and empower people to be more in control of their support.
• Staff spoken to were approachable and positive about the support they offer. A staff member told us they, "Like to spend as much time with the customers as they can".

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 management team understood their legal obligations including the conditions of their registration. An electronic system was in place to ensure the Care Quality Commission and local safeguarding team were notified as required following an incident.
• Family members would talk to management if they had any concerns. A family member told us, "I'm always happy to talk to them if I have any problems".
• Following a recent incident the operations director had responded to the family of the person supported. The operations director apologised for the distress caused by this incident and what processes have changed following this incident to prevent a reoccurrence.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff received supervisions and attended staff meetings. Staff told us these had been completed regularly.
• The registered manager explained that due to difficulties during the pandemic they have not been able to hold individual review meetings with the person supported and their family member. The registered manager is planning to arrange this as soon as possible.

Working in partnership with others
• The service worked alongside health and social care professionals as required when supporting the people to ensure their health needs were met.

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 Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were risks to people's safety associated with the services environment and equipment used. Risks to people, and the planned actions to help mitigate them were not adequately planned, adhered to or monitored. 1, 2 (a) (b) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance. Systems for monitoring and improving the quality and safety of the service and having regard to the accuracy of records were not operating effectively. 1, 2 (a), (b), (c) (d) (e) (f)