Kisimul Group Limited

Tigh Fruin

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
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
Tigh Fruin is a residential care home providing personal care to people with learning disabilities and autism. The service is a three-story building in the small village of Hayton. Each person has their own bedroom and ensuite facilities. There are communal spaces for dining, living and creative space for activities. The service can support up to six people, and there were six people using the service at the time of the inspection.

People's experience of using this service and what we found
There were not always enough staff to keep people safe or to provide them with the individual support they were assessed as needing. People were not always protected from the risk of abuse.

The service was not always well-led. Prior to April 2021, the provider had not ensured that their systems and processes were robust enough to identify a number of issues that potentially put people at risk. Relatives were disappointed with communication during the pandemic and felt that getting information about visiting and updates on their family members was difficult. Not all staff were up to date with training the provider expected them to do.

People were not always involved in reviews of their care, particularly where they were less able to communicate their needs. Relatives said they felt staff, particularly newer or agency staff, did not always consistently support people's communication effectively.

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. The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. For example, people's support was not always planned with them, and they did not always have a choice about who they lived with.

People's needs were assessed, and any risks associated with their health conditions documented. Risks associated with the service environment were assessed and mitigated. People received their prescribed medicines safely. Accidents and incidents were monitored to identify trends and to prevent reoccurrences. The service was clean.

People were supported to eat and drink well, and to have a balanced diet. People were encouraged to make choices about decorating their personal space, and their bedrooms were clean and personalised. People's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. People had access to GP, dentist services and other healthcare professionals.

People's care was provided in ways which promoted their dignity and respected their independence. Staff

respected people's right to confidentiality. The provider had a system in place to respond to complaints and concerns. The coronavirus lockdowns had an impact on people's ability to go out and enjoy places and activities that had previously been part of their normal routines. Staff had worked hard to try and ensure there was still a variety of Covid-safe activities for people to take part in if they wanted. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The manager had a good understanding of their role and responsibilities to manage and lead the service consistently well. Following local authority safeguarding investigations for several people living at Tigh Fruin, the provider worked with local authority staff to ensure lessons were learnt and improvements were made in the way people were supported.

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 Outstanding (published 15 April 2020).

Why we inspected
The inspection was prompted in part due to concerns received about another service run by the provider and concerns raised by the Local Authority, which included poor governance and oversight. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 have identified a breach in relation to Regulation 18 (Staffing) as the levels of staff support were not consistently safe. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will continue to monitor information we receive about the service until we 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Tigh Fruin

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of one inspector.

Service and service type
Tigh Fruin 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. At the time of our inspection the registered manager was not available. The provider had arranged for an interim manager to support the service during the registered manager's absence.

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. We sought feedback from the local authority about the service. 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. We used all of this information to plan our inspection.

During the inspection
During the inspection we observed how care and support was given generally. We got feedback from five relatives. We spoke with four staff, the manager, the area manager, and the provider's director of adult services. We looked at a range of records including two people's care records and how medicines were managed for people. We also looked at staff training, and the provider's quality auditing system. During the inspection visit we asked the provider to give us additional evidence about how the service was managed and they sent this to us.

After the inspection
We continued to seek clarification from the provider regarding the evidence we had. We sought feedback from the local authority safeguarding staff, and quality monitoring team, and from commissioning bodies. We also sought feedback advocacy services who were involved in supporting people.

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 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.

Staffing and recruitment

- There were not always enough staff to keep people safe or to provide them with the individual support they were assessed as needing. Concerns about staffing levels had been shared with CQC prior to this inspection.
- Relatives expressed concerns about the number of staff who had left the service, and were worried that new staff and agency staff did not always have the right experience and skill to support their family members safely.
- Evidence from the provider's staff rotas specified the required number of staff hours needed for each shift, and showed where the service was short of the required hours needed. In August 2021, there were 13 days when staffing levels fell below the hours needed. In the same month, there were nine nights when there were not enough staff. Evidence from staff in the daily handover records supported this.
- The management team confirmed recruitment was an issue for the provider, and they were continuously trying to find ways to remedy this. Nonetheless, there were times when people were left without the staff support they were assessed as needing, and this put them at risk.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse. Prior to April 2021, there were a number of safeguarding concerns which staff had not reported. These concerns were identified as part of a local authority safeguarding investigation into another matter. As soon as the provider and manager were made aware of these concerns, they worked with the local authority to ensure people were safe. However, this meant there were times in the past where staff had not spoken up to ensure people were kept safe from the risk of abuse.
- Some relatives expressed concerns that there had been incidents between people that could have been avoided. Relatives felt the likelihood of incidents occurring could have been reduced if people had been supported by staff who knew them well, or if there had been the right level of staff support for each person.
- Staff we spoke with on inspection understood how to recognise and report concerns or abuse, both to the provider and to external agencies. They were able to give examples of how they would identify when someone was at risk of abuse and were clear on their responsibilities to report concerns. Staff received training in safeguarding and felt confident to raise concerns about the people they cared for.
- The manager reported any allegations or abuse to the local authority safeguarding team and notified CQC about this. The provider had policies on safeguarding people from the risk of abuse and whistleblowing, and

staff knew how to follow these.

Assessing risk, safety monitoring and management
● People's needs were assessed, and any risks associated with their health conditions documented. These were reviewed regularly and updated when required. Staff knew about risks associated with people's health conditions and understood how to provide care which kept people safe.
● Risks associated with the service environment were assessed and mitigated. The provider had a clear system in place for regular checks on environmental risks.
● The provider had plans in place to guide staff in what to do in an emergency, for example, if there was a fire or power cut.

Using medicines safely
● People received their prescribed medicines safely. Staff received training about managing medicines safely and had their competency assessed. Staff told us, and evidence showed that overall, medicines were documented, administered and disposed of in accordance with current guidance and legislation.
● People received their 'as and when' (PRN) medication when they needed it. There was guidance in place for people's PRN medicine which told staff when this medication was needed.
● The system for managing medicines ensured people were given the right dose at the right time.

Preventing and controlling infection
● The service was clean. Staff carried out a range of daily cleaning activities, including enhanced cleaning to reduce the risk of coronavirus and other infections. Cleaning was recorded and audited by the manager to ensure the service remained hygienic and safe.
● We were assured the provider had made provision for admitting people safely to the service. We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules wherever possible. Social distancing was not always possible for staff when providing 1-1 support or intimate personal care. The provider was using PPE effectively and safely. The provider was accessing testing for people using the service and staff.
● The provider was making sure infection outbreaks could be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date. The provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Several incidents had occurred between people. These were reported as safeguarding concerns to the local authority. The provider also did their own investigation and identified specific triggers for the incidents. People's care plans and the support they received was reviewed and changed. This reduced the risk of further incidents.
● Accidents and incidents were monitored to identify trends and to prevent reoccurrences.
● Individual incidents were reviewed, and action taken to address immediate concerns. For example, to obtain specialist support for people, or to review people's needs.
● The manager confirmed there had been a lot of work recently to improve how accidents and incidents were documented, followed up and analysed to make people's care safer. The provider had improved their processes for analysing incidents to determine how to improve the quality of care.

Good

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 Outstanding. At this inspection this key question has now deteriorated to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- The provider expected staff to undertake a range of mandatory training courses, including first aid, safeguarding, medicines competency and positive behaviour support. Not all staff were up to date with this training or the refresher training the provider expected them to do.
- We noted staff were expected to complete an "introduction to autism" course, and the provider did not require any more in-depth training. None of the staff were being supported to obtain any external qualifications. For example, the nationally recognised level 2 or 3 in Health and Social Care. This put people at risk from receiving support from staff who were not trained to meet their specific needs.
- Daily handovers were recorded, so that staff had an accurate record of how they shared key information about people's needs each day.

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

- People's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Assessment of people's needs, including in relation to protected characteristics under the Equality Act 2010 were considered in people's care plans.
- The provider had introduced the use of a nationally recognised tool to help staff identify a wide range of signs and behaviours of distress and also when people are content. This helped staff have confidence in advocating for health care or a change in support, particularly where people cannot clearly communicate verbally.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink well, and to have a balanced diet. Staff knew about each person's food and drink likes and dislikes. A weekly menu helped people and staff to plan their food shopping and meal preparation.
- Staff confirmed that breakfast and lunchtimes were flexible, depending on what people were doing each day and what they wished to eat. We saw that an evening meal was prepared that would suit everyone, but people were also offered an alternative if they wished.
- People who needed support to have food prepared a particular way received this. There was guidance available in the kitchen for staff to ensure they followed health professional recommendations.

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

- The décor of the communal areas was uncluttered and simple, to help reduce the risk of people becoming overstimulated by their surroundings and anxious in the service.

● People were encouraged to make choices about decorating their personal space, and their bedrooms were clean and personalised.
● People had access to a large secure garden, where they could spend time when they wanted. Staff said this was helpful for some people who sometimes needed a safe outside space to move about and reduce anxiety. The garden was also used for outdoor games and activities when people wanted to do this.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to GP, dentist services and other healthcare professionals. Relatives said staff contacted them if their family member needed external healthcare services. Care records showed staff regularly contacted health professionals for advice if they were concerned about people's well-being.
● Advice from healthcare professionals was incorporated into people's care plans so staff knew how best to support people.

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.
● Assessments of people's capacity for specific decisions detailed how information about each decision was given. People who needed additional aids to help them understand choices were given this support.
● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.
● Staff received training in consent and capacity and understood how to support people to make their own decisions as much as possible.

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

- People were not always involved in reviews of their care, particularly where they were less able to communicate their needs. Staff said reviews of people's care plans were not always done with people, and records confirmed this. People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats.
- Relatives said they felt staff, particularly newer or agency staff, did not always consistently support people's communication effectively. For example, two relatives described a lack of consistency in staff using people's preferred communication methods. They said this could lead to frustration for people, linked to a lack of understanding of what was happening, or not being understood.
- Staff told us they had training in basic Makaton, but evidence confirmed this was not consistently used to support verbal communication. People who had particular communication needs did not have sufficiently detailed care plans for staff to follow. We identified with the manager that communication care plans needed more information regarding individual people's non-verbal body language. This would help staff develop a more consistent understanding of each person's unique communication styles.
- The manager had recognised that staff did not always have a consistent approach to demonstrating effective communication. They were working on improving staff skills and confidence in different types of non-verbal and assistive technology for better communication.
- For people who needed support to make decisions regarding their care in the absence of family support, independent advocacy services were made available. This meant people had access to someone who could speak up on their behalf if they needed it.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff had received training on equality and diversity and respected people's wishes and needs in accordance with the protected characteristics of the Equality Act 2021.
- We saw people using the service felt comfortable around staff, and interactions were unhurried, positive and friendly. Care and support was offered by staff with warmth and good humour to everyone we saw.

Respecting and promoting people's privacy, dignity and independence

- People's care was provided in ways which promoted their dignity and respected their independence. Staff had a good understanding of dignity in care, including respecting privacy by knocking on doors before entering, and ensuring intimate personal care was carried out with dignity.
- People were encouraged to maintain relationships that were important to them. Although relatives' visits had been restricted during the coronavirus lockdowns and outbreaks, the provider was now supporting people to meet with relatives in accordance with the government guidance.

● Staff respected people's right to confidentiality. They ensured that any conversations about people's care were discreet. Staff understood when it was appropriate to share information about people's care, and records relating to people's care were stored securely.

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 Outstanding. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The provider had a system in place to respond to complaints and concerns. Relatives were not always confident concerns or complaints would be escalated to the right staff member and dealt with. There was also no evidence about how people with limited or no verbal communication were supported to express their views in order to make a complaint.
- Staff we spoke with knew how to respond to concerns raised and their need to record and escalate them.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were not always regularly asked for their views about their care. Relatives were involved in reviews of people's care where this was appropriate.
- People were not consistently involved in planning and reviewing their care. Staff told us, and we saw people were supported to express their opinions (using their preferred ways of communicating) about their daily lives, but this was not consistently evidenced in care records. For people who were less able to communicate verbally, there was insufficient evidence about how staff sought their views. Although staff we spoke with were knowledgeable about people's preferences and lifestyle choices, this information was not always recorded. There was a risk people's views and information about their lives were not available to support all staff in providing care.
- People were supported to practice their faith if this was important to them. Staff spoke with people and relatives about any needs associated with faith or culture to ensure these needs were met.

End of life care and support

- No-one at Tigh Fruin was receiving care at the end of their lives at the time of our inspection. However, we looked at how end of life care was planned. There was no evidence that staff were trained or supported to discuss end of life care planning with people and their relatives. People and relatives were not supported to discuss their views and wishes on care at the end of life if they wished to do so. This put people at risk of not being supported in ways they and their relatives wanted in the future.

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.

- The service identified people's information and communication needs by assessing them. People's communication needs were recorded in care plans, and this information was shared appropriately with

others. The provider asked people and relatives about their communication needs and could provide information about the service in various formats when needed. For example, in large print.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The coronavirus lockdowns had an impact on people's ability to go out and enjoy places and activities that had previously been part of their normal routines. Staff had worked hard to try and ensure there was still a variety of Covid-safe activities for people to take part in if they wanted.

● Relatives were aware that coronavirus had affected people's opportunities to go out and about for a considerable period of time. Some relatives said their family members were not always supported to have contact using technology as frequently as had been agreed with staff (for example, via phone or computer-based applications).

● People were encouraged to participate in activities to suit their mood throughout our inspection. Staff demonstrated good knowledge of each person's preferences and tried to ensure that everyone had daily opportunities to do meaningful activities that made them happy.

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.

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

- The service was not always well-led. Prior to April 2021, the provider had not ensured that their systems and processes were robust enough to identify a number of issues that potentially put people at risk. This included identifying time and places which were possible trigger points for people becoming anxious and distressed. This had led to several safeguarding incidents which were potentially avoidable.
- Staff at the service had not always spoken up in relation to concerns about people's wellbeing. This had led to delays in the provider taking action to keep people safe.
- There had been a high turnover of staff at the service. The provider was working to address this, but there had been an impact on people. One relative said, "Due to the current staffing issues within the service there have been incidents involving my family member. Each time I am provided with feedback regarding management plans to address this, however due to the turnover of staff and use of agency staff these incidents continue to periodically occur as staff are unfamiliar with these plans."
- Staffing levels were not always sufficient to meet people's assessed needs and their commissioned packages of care.
- The provider had plans in place to address all these issues, and kept this under review to ensure there was progress to improving the quality of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives were disappointed with communication during the pandemic, and felt that getting information about visiting and updates on their family members was difficult. One relative said, "There is no contact unless we chase for information." Another relative said, "They don't seem to communicate well or follow up on issues we raise."
- Feedback from staff about how they were supported and managed was mixed. Some staff felt historically they had been unsupported, their concerns not listened to or acted on, and not having clear roles and responsibilities on shift. This had an impact on both the quality of care and staff well-being. The provider was working to address these issues. However, other staff felt well supported and listened to.
- Feedback from local authority staff reflected issues we identified regarding staffing levels and communication.

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements; 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 undertook audits of all aspects of the service to review the quality of care, and identify areas where improvements were needed. This included a range of regular checks on all aspects of people's care and the building environment. There was a plan arising from audits to show what action was required and who was going to do it. This meant any issues were dealt with in a timely way.

● The manager had a good understanding of their role and responsibilities to manage and lead the service consistently well. They had been in post since April 2021 and were working to identify areas of the service that required improvement.

● The staff team understood their roles and were open and honest during our inspection. The provider and staff team we spoke with were positive about improving the service.

● The provider had notified us of all significant events which had occurred in the home in accordance with their legal responsibilities.

● The provider was displaying their ratings from the previous inspection as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

Continuous learning and improving care; Working in partnership with others

● Following local authority safeguarding investigations for several people living at Tigh Fruin, the provider worked with local authority staff to ensure lessons were learnt and improvements were made in the way people were supported.

● The manager and staff team worked with external health and social care professionals to improve people's care and quality of life. Since the start of the coronavirus pandemic in March 2020, visiting health and social care professionals had reduced their face to face contact with people in the service. However, the staff continued to keep in contact with them using a range of technology. This meant people continued to get support from their local health and social care services.

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 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to keep people safe or to provide them with the individual support they were assessed as needing.