Omega Elifar Limited

The Firefly Club Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
The Firefly Club is a residential care home providing personal care and accommodation to 6 people at the time of the inspection. The service can support up to 8 people.

People's experience of using this service and what we found

Right Support: People were not supported to have maximum choice and control of their lives. 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 provider was not able to demonstrate how they were meeting the underpinning principles of right support, right care right culture. The service was not maximising people's choices, control or independence.

Right Care: People were not always supported to make meaningful choices. There was a lack of person-centred care and people's human rights were not always upheld. People were not supported to lead inclusive and empowered lives. People had care plans in place. However, these were not always written in a way that was person centred and easy to understand; we found inconsistencies in care plans, a lack of detail and care plans which had not been updated to reflect the current support people were receiving. People were at increased risk of not being supported in the least restrictive way possible and in their best interests.

Right Culture: The service was not well led. The quality assurance systems to assess and monitor the service were not always in place, and where they were, they were not effective. We found the provider did not have enough oversight of the service to ensure it was being managed safely and quality maintained. Quality assurance processes had not identified all of the concerns in the service. Records were not always complete. Indicators of a closed culture were identified, and staff morale was low. Staff did not feel confident in raising concerns with the provider. This meant people did not always receive high quality care. We have made a recommendation related to safeguarding.

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

Rating at last inspection
The last rating for the service was good (published on 30 May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about governance and concerns shared by the local authority relating to care planning, risk management, staffing and medicines. A decision was made for us to inspect and examine those risks.

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

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

Enforcement and Recommendations
We have identified breaches in relation to staffing, person-centred care, safe care and treatment, premises and equipment, assessing and monitoring risk and good governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
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 well-led. Details are in our well-led findings below.	**Inadequate**

The Firefly Club Care Home

Detailed findings

Background to this inspection

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

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
This inspection was carried out by 1 inspector.

Service and service type
The Firefly Club is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Firefly Club is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

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 used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from the local authority and professionals who work with the service. We used information gathered as part of monitoring activity that took place on 24 November 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spent time in shared spaces with 5 people; getting feedback and observing the quality of care and support they received. This helped us to understand the experiences of people who we were unable to communicate with effectively. We received feedback from 8 members of staff including the nominated individual, deputy manager and 6 care staff, including agency staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included support planning documentation, including medicines records, for 6 people. We looked at 6 staff files in relation to recruitment and supervision records. We also reviewed a variety of records relating to the management of the service, including risk assessments, quality assurance records, training data and policies and procedures. We received feedback from 5 relatives and 1 professional.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- We found risks to people were not managed safely. The provider had not fully recognised the risks faced by people living in the service.
- We found several concerns relating to the quality of the care plans and risk assessments. Such as; care plans and risk assessments not always containing enough detail to ensure people were supported safely, some care plans containing out of date information and not reflecting the support being provided to people, some care plans containing contradictory information, some people not having completed care plans or some people having care plans in place which had been written by a previous provider with the information relevant to a different location and support requirements. This meant people were at an increased risk of harm by being supported by staff following inconsistent care planning documentation.
- For example, two people's care planning documentation in relation to bowel management support contained conflicting information in two different care plans, one person's care plan was created by a previous provider and referred to training which staff at The Firefly Club were not trained in and one person had a care plan which was no longer relevant.
- In addition, the feedback we received, along with our observations, evidenced the support being provided to people was not always reflective of the care planning documentation in place. For example, one person was not being supported in accordance with their care plan and risk assessment which had not been reviewed or updated following the change in support. The staff team had supported the person with positive risk taking and enabled the person to be supported with fewer restrictions. However, their care planning documentation had not been updated to reflect this change in support.
- We found risk assessments did not always contain enough detail to ensure people were supported safely, contained information which was not accurate at the time of the inspection or for some observed risks, no risk assessment was in place. For example, where staff had supported people to take positive risks, there was no documented risk assessments in place. Whilst staff mitigated some of the risks through verbal risk assessing and contingency planning, the lack of a documented risk assessment placed staff in a vulnerable position and meant the provider did not have oversight of the measures put in place to manage and respond to the risks. It also meant there could not be a robust review of what worked well, what could have worked better, and lessons learnt.
- Incidents where people became distressed or anxious were not effectively recorded. For example, for 2 people there were multiple records stating they had been supported to their room during heightened states of anxiety. There was no detail stating how they were supported to their room, especially during times where they were physically aggressive towards others. The lack of detail meant it was difficult to identify patterns and triggers to inform reviews and updates of care plans and to mitigate risk of further incidents. In addition, we saw no evidence of any de-briefs being offered to people or staff involved in incidents.

The failure to assess and do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection the provider had started to update people's care planning documentation and were working with healthcare professionals to achieve this. However, not all the concerns identified on inspection had been identified by the provider and there was no clear risk management approach to the updating of the care planning documentation to ensure the highest priority documentation was updated promptly.

● There were some safety concerns in relation to the environment.
● Fire safety was not always effectively managed. Documents relating to fire safety were not consistently completed. For example, emergency lighting checks, weekly portable equipment checks and daily tumble dryer lint checks. This meant the provider could not be assured the premises remained safe for people.
● We found health and safety checks were either not in place or not consistently completed. For example, there was no evidence of regular wheelchair checks or other moving and handling equipment safety checks taking place. Staff we spoke with confirmed these checks were not in place. This meant there was an increased risk of people being supported to use equipment which had not been properly checked and maintained.
● Health and safety checks were not in place for moving and handling equipment. For example, there were no effective wheelchair checks in place. Although there was a monthly health and safety audit which specified visual wheelchair checks and dates completed, the comments section provided no dates and stated they were visually checked before use. Regular monitoring and maintenance ensures wheelchairs are operating safely. Another example was the handling belt for one person. There was no evidence regular checks were carried out to ensure it remained safe to use and had no defects.
● We found there was outstanding maintenance required with no evidence of planned completion dates for some of the identified concerns. For example, 2 fire doors in the corridors had broken door stops. We saw no evidence these had been reported and acted on. A staff member told us this prevented the doors from being able to stay open without using placing something under the door to prevent it shutting. This was a fire risk. The nominated individual told us the automatic release function was not broken on the doors and was able to be still be used. They assured us they were booked for repair and were known to the provider; they had broken due to wear and tear. We were concerned there was a risk of staff propping fire doors open with items which would stop the doors from automatically closing in the event of a fire.
● We saw an action plan which detailed some planned for physical environment improvements which had completion dates recorded or updates detailing the progress made but this was not specifically to record maintenance actions. We were not assured the process was effective in resolving maintenance concerns. Staff told us they verbally reported maintenance requests and would not get any feedback on the status, progress or completion of requests. One staff member told us, "All verbal. I don't get why we don't have a recorded process. I find it frustrating." This meant there was a risk of required maintenance not being reported if staff believed someone else had reported it.

The failure to ensure the premises and equipment was properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We could not be assured the service were always following safe recruitment practices.
● We looked at 6 recruitment files for staff that been employed in the past year which showed that appropriate checks had not always been undertaken prior to them being employed. Five out of the 6 staff files reviewed had gaps in their employment histories. For example, for 1 person had 2 gaps, one of which spanned several years. For another person there were 3 gaps spanning several years and for one of their

employment records they had not recorded a start or end date. Schedule 3 (7) of the Health and Social Care Act (Regulated Activities) Regulations 2014 requires providers to make available to CQC a full employment history, together with a satisfactory written explanation of any gaps in employment.
● We could not be assured the provider had satisfactory information about any physical or mental health conditions which are relevant to a staff member's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment. All 6 files reviewed had health questionnaires which had not been reviewed or completed by the manager. Where the questionnaires identified health conditions which may have impacted on their capability, there was no evidence this had been followed up with by the provider to identify any reasonable adjustments required.

The failure to follow safe recruitment procedures was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback about the staff files, the provider told us they would be reviewing all staff files.
● The planned staffing levels were based upon the amount of one to one, two to one and shared care hours that each person had been assessed as needing by their commissioners.
● We reviewed the rotas for the 2 weeks of the inspection and the previous week. These were hard to interpret, but along with the daily allocation sheets, mostly provided assurances that planned staffing levels had been met.
● There was no effective system in place to monitor that people's two to one hours were being provided. For example, the staff allocation sheets in place did not provide sufficient detail. The provider told us they exported weekly data which confirmed people's hours had been provided. We requested a sample of this data but were not provided with it. This meant we could not be assured the provider had effective processes in place to know how these hours were being used to give people individualised support. For example, to access the community.
● Most relatives and staff told us there were enough staff to meet people's needs but there was a reliance on agency staff to ensure safe staffing levels. The provider told us, and we saw evidence, they were making progress on reducing the number of agency staff needed.
● The nominated individual was open about the recruitment challenges the service was experiencing and told us about the different initiatives the provider had introduced to recruit more staff. For example, they had developed wellbeing initiatives for staff, had a rolling recruitment advertisement and had a recruitment incentive for staff referrals.

Using medicines safely
● We could not be assured medicines were managed safely.
● Some people had been prescribed medicines to be used 'as required' (PRN). These medicines need PRN protocols to explain their use and how much to give, or when to use the medicine. PRN protocols were in place however; they did not always contain enough information. For example, one person was prescribed PRN Senna. The directions for PRN Senna stated, '1 or 2 tablets at night when required.' The PRN protocol did not provide any guidance to support staff in the administration of this medicine to be able to identify when 1 tablet or 2 tablets were required. This meant the person may not be supported to have the dose they needed administered.
● We found multiple gaps on medicine administration records (MARs) for 3 people. This meant these medicines had not been given or had not been signed for. There was no evidence these gaps in MAR charts had been identified and acted on.
● We found handwritten MARs which had not been completed in full. For example, the allergies box on the MARs had been left blank. In addition, there was no signature or date of the person who had written the MAR or the signature of a witness. We spoke to the nominated individual about this who told us this was not in-

line with the provider's policies and procedures in relation to handwritten MARs.

We found no evidence people had been harmed however, systems and processes were either not in place or not robust enough to demonstrate safe medicines management. The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection the local authority had identified medicines had not always been available to people. For example, one person had not had a medicine administered for several days due to the pharmacy having none in stock. The nominated individual told us they planned to review medicines within the service and had implemented a new medicines audit. They told us this would enable them to monitor stock levels of medicines within the service and to respond promptly to the lack of availability of medicines in pharmacies.

Systems and processes to safeguard people from the risk of abuse

- Relatives told us they felt people were safe. Comments included, "I believe [person's name] is safe", "I do indeed [when asked if they felt their loved one was safe]" and "Yes I think so."
- The provider had systems and processes to safeguard people from the risk of abuse.
- Staff understood their safeguarding responsibilities but not all staff felt appropriate action would be taken by the provider or felt confident in reporting concerns to the provider. Staff felt confidentiality was not always maintained and some staff told us they would feel at risk of personal repercussions were they to report concerns to the provider. Comments included, "There is a fear of speaking out, something really does need to change and it needs to be from the top down", "I don't feel I can say anything to the managers here at the moment, I don't trust them", "We are all in limbo and don't know who to go to" and "I have some concerns about sharing with managers."
- Staff demonstrated they were aware there were other organisations they could report concerns to and were able to describe example of safeguarding concerns. However, we found not all staff had training in safeguarding, or where they did have training it was not always in-date. We have reported on this in more detail in the effective domain of this report.

We recommend the provider review their safeguarding procedures and systems with staff in line with recognised best practice to ensure staff understand them and have confidence in using them.

Learning lessons when things go wrong

- Systems in place to promote staff learning and development were ineffective. We found incidents had not always been investigated to identify any lessons to be learnt. There was a lack of analysis of trends and patterns in relation to accidents and incidents. We observed there had been some accidents and incidents which had not had any follow-up, response or investigation by the provider. For example, we observed there had been incidents where injuries had been received by staff when supporting people and there was no evidence of any de-briefs with staff to identify any lessons learnt, wellbeing checks or a review of any relevant care plans or risk assessments.
- Another example, we saw two completed records of incidents involving the same person on different days. They detailed similar incidences and circumstances, but the approaches taken by staff were not consistent. This meant the person was not receiving consistent support and could have increased their anxiety or distress increasing the risk of harm to themselves and/or others.
- Since the inspection the provider had introduced de-briefs for staff and were implementing an electronic care planning system which would enable them to analysis accidents and incidents to identify trends and patterns. However, these needed time to be embedded within the service and development of staff to identify what information they need to include to be effective.

Preventing and controlling infection; Visiting in care homes

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found the cleaning schedules had not been consistently completed and there were several gaps. On the first day of inspection we found two used lateral flow device tests which had not been discarded of appropriately. The provider had a clear procedure for staff to follow when carrying out testing which had clearly not been followed.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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 responding effectively to risks and signs of infection.

● 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.

● The provider facilitated visits for people with their relatives and friends in accordance with government guidance. Relatives confirmed they were able to see their loved ones when they wanted to and people were supported to contact them via video calling when they wanted to. One relative told us, "[Person's name] face-to-face calls us when he misses us."

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The provider had not ensured there were sufficient numbers of suitably competent and skilled staff to support people safely.
- We reviewed the training matrix and found not all training had been delivered for staff to be able to fulfil their role effectively. This included statutory training such as, safeguarding, fire safety and moving and handling. As well as training specific to the service such as epilepsy, buccal midazolam administration, autism awareness, Mental Capacity Act and learning disabilities awareness.
- For example, we found of the 14 staff employed directly by the service, only 6 staff had evidenced training in 'Learning Disability Awareness'. Of those 6 staff we found 3 staff's training had expired and was out of date. Another example, we found only 5 of the 14 staff employed directly by the service had received training in 'Supporting People with Autism'. The provider supported people with a learning disability and autistic people, ensuring staff are trained appropriately improves the experience and outcomes for the people they support.
- Another example, of the 14 staff directly employed by the service only 6 staff had received training in 'Buccal Midazolam Administration'. Of those 6 staff we found 4 staff member's training had expired; 2 of the staff's training had been out-of-date for over 1 year. 'Buccal Midazolam' is a rescue medicine and one person was prescribed this medicine. This meant they were at an increased risk of not receiving this medicine promptly when needed in an emergency.
- The provider had 'staff allocation sheets' which were completed daily. These recorded the names of staff working and what service specific training they had. We found these were not completed consistently. This meant there was a risk there were not enough trained staff available to support people. In addition, we found examples where the staff working had the training ticked when they were out of date in that training. One staff member told us, "They will tick NAPPI training for me but it was XXX ago and has never been refreshed."
- We reviewed 7 agency staff profiles. These detail what training the agency staff have received. We found only 1 of the agency staff had received training in 'Autism Awareness'. For 1 of the agency profiles there were no dates recorded for any training. This meant the provider could not be assured the agency staff had received the appropriate training to support people at The Firefly Club.
- Agency staff did not receive Non-Abusive Psychological and Physical Intervention (NAPPI)' training. We were told the risks were mitigated because there were enough numbers of directly employed trained staff available to support if required. However, the allocation sheets and training matrix did not evidence this. This meant people were at an increased risk of harm by being supported by staff who were not adequately trained.

● There were identified support strategies in place to support incidents where people may become distressed or anxious which could impact on their safety and/or others. These strategies included the potential use of physical interventions as a last resort, to be carried out by NAPPI trained staff only. The care planning and risk management and risk management documentation was not clear on how many NAPPI trained staff were required as a minimum within the service and when supporting people when outside of the service. For example, there were 2 conflicting documents which meant people were at risk of being supported in the community by adequately trained staff or were limited when they could access the community if not enough adequately trained staff available to support them.
● We reviewed a sample of allocation sheets and found the number of staff who were trained in NAPPI working varied. For example, there were some days where there was only 1 NAPPI trained member of staff working, and on some of those days it was a staff member whose training had expired. One staff member told us, "I don't know how the ratio works … I do know I have been the only one left behind trained with agency staff who were not trained. I felt I had to be there every second, it was on my head and scared to even go for a [comfort break]."
● The provider had not demonstrated they had considered the potential risks of more than 2 staff being required to support more than 1 person in an incident and taken action to mitigate those risks. Such as, the potential impact of new or agency staff who were less familiar to people with care planning documentation which lack the detail to ensure people were supported safely. There was a concern people's anxiety could be heightened if supported inconsistently by staff who are not as familiar to them, their preferences and needs. This meant there was an increased risk in the likelihood of incidents where people's anxiety or distress could put their safety and/or others safety at risk.
● We found staff had not been supported with consistent supervisions or team meetings. We reviewed 6 staff files in relation to support and supervision. In all 6 files we found supervisions had either been completed inconsistently or had not been provided to staff at all. For example, one staff member had no evidence of any supervisions over a period of 10 months. Comments from staff included, "I think a lot of the staff are really demoralised and we are all struggling", "[Nominated individual's name] keeps saying we need to catch up but doesn't ever have time" and "I've had a supervision once if 5 months, can't remember when that was."
● Staff employed directly by the service received a formal induction into the service. However, we found records relating to induction were not always consistently completed.
● The provider had different competencies they carried out with staff. Such as, handwashing competencies, and medication practical competencies. We found these had not been completed consistently with staff, which meant that the provider could not assure themselves that staff had understood and were carrying out their roles as they had been trained.

The failure to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We were concerned people were not supported to have maximum control of their lives and that staff were not always supporting people in the least restrictive way possible. Whilst we observed people being offered choices and being supported at their pace, the documentation and records did not always evidence this. For example, documented records recording people had been asked to wait for a snack when requested with no detail explaining the staff member's rationale.
● For people that the service assessed as lacking mental capacity for certain decisions, there were some recorded assessments and best interest decisions. However, some of these were vague and lacked sufficient detail with no evidence how decisions made were least restrictive. This meant people were at increased risk of inappropriate or abusive restrictive practices.
● The provider had made appropriate DoLS applications. However, we found one person had 2 conditions which the provider could not evidence they were compliant with. We were concerned this placed the person at an increased risk of being supported by staff who were not trained or competent in supporting them with a restrictive moving and handling aid. Staff told us they had not been trained in using the aid and no competency checks were being carried out. The risk assessment and care plan relating to the aid were not being followed by staff and had not been reviewed or updated. Staff told us they had supported the person to develop their independence and was being supported to reduce restrictions in relation to the aid, but this had not been documented. We were not assured the provider was complying with the DoLS authorisation and placed this person at an increased risk of harm.

The failure to act in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our feedback, the nominated individual told us they would be reviewing people's assessments and best interests records.

Supporting people to eat and drink enough to maintain a balanced diet
● People were able to input into choosing their food and planning their meals. Staff offered people opportunities to be involved in preparing and cooking their food and drink where staff had the confidence and skill to support people. One relative told us, "I've seen [person's name] in the kitchen doing all the basic prep and cleaning and rinsing plates."
● The nominated individual told us, and staff we spoke with confirmed, there were no restrictions on people being able to access food and drink when they wanted. However, whilst we observed people being able to have food and drinks when they wanted, the care planning documentation did not always reflect this. We saw recorded occasions where people had requested food but had not been supported to have something to eat. For example, one person requested something to eat during the night. The documented record stated, 'He indicated on PEC board he wanted a snack. Staff said it was time for bed, not snack time'.
● The nominated individual understood the risks of poor nutrition and knew how to access additional resources if required. Such as dietician support. People were supported to be regularly weighed. However, the recordings were not as clear as they could be. Sometimes recordings were in kilogram and sometimes pounds. In addition, there was no guidance available to staff to guide them when to escalate concerns. The nominated individual told us this would be reviewed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care and support plans did not always reflect people's needs. Not all people had relevant assessments in

place, such as communication and sensory assessments. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care.
● The provider was aware of this and was in the process of working with health and social care professionals to implement person-centred care planning documentation for people. Where appropriate relevant assessments were being carried out. For example, one person had been identified as benefiting from being supported to use Makaton.
● One professional had recently delivered Makaton training to some of the staff. Makaton is a unique language programme which uses symbols, signs and speech to support people to communicate. Staff told us they had requested Makaton training prior to the involvement of the professional. One staff member told us, "We were waiting for Makaton for ages and as a team we researched it ourselves and discussed it … Watching 'Mr Tumble' and telling each other what it meant ... we've had it now due to [person's name's] assessment."
● Initial assessments were completed with people prior to them moving into the service. Relatives told us they had been involved in assessing and planning people's move to the service and had been asked about people's support needs and preferences. One relative told us, "I think transition wise went really well."

Adapting service, design, decoration to meet people's needs
● People confirmed they were happy with their rooms. People's rooms were personalised. Some people told us, and evidence seen reflected this, they had been involved in making decisions about their bedrooms and the décor.
● The service was spacious with large shared spaces. There were 5 different spaces people could access if they wanted to. For example, the dining room, lounge, library, activities room and a smaller lounge. If people wanted privacy, they had several choices. Each bedroom had an ensuite.
● Relatives were mostly positive about the environment. However, one relative told us the environment would be improved by enabling access to the grounds and garden more easily. The provider was in the process of resolving the access concerns; we saw updates and progress recorded on their action plan.
● Some staff shared some concerns about the environment; the delay to resolving maintenance concerns and replacing broken items. For example, the freezer in the kitchen broke and a smaller temporary one was put in place until a new one could be arranged. However, the smaller freezer was unable to fully meet the needs of the service. One staff member told us, "The freezer has been broken for over 5 weeks … We have a tiny freezer so can't have much food."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had good access to physical healthcare and were supported to live healthier lives. We saw evidence of various professionals involved in ensuring people's needs were met. For example, appropriate referrals had been made to the community learning disabilities team.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● We observed some people being encouraged by some staff to do tasks for themselves during the inspection. For example, to carry their dishes to the kitchen. Staff told us how they supported people to maintain their independence. For example, engaging in some household tasks.

● Comments from relatives include, "Got him involved in the shopping; he likes contributing to that" and "[person's name] hadn't been home over 3 years due to Covid. Recently staff doing social stories with him and supporting him to come home was really positive for us."

● However, people were not always supported to maintain, or develop, their independence. Care planning documentation did not always promote independence and where staff have identified areas for individuals to support them to develop independence there was no consistent approach; there was no documentation to support their approaches and staff relied on verbal handovers of new approaches. This meant there was a risk of people being supported inconsistently.

● Although there was some goal planning in place, people had not been supported to be involved in identifying their goals and there was a lack of guidance in how to support people to work towards achieving their goals. For example, one person had a 'daily living skills' care plan which did not detail how to support the person, how to support them to develop and progress and no records of progress and reviews.

● People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy. Staff knocked on people's doors and waited for permission before entering.

● People were being supported to widen their experiences and activities. New activities were being sourced for people. However, documentation was not being used effectively to support this; details about activities were brief and no information about how people had responded to the activities and what had worked well. The nominated individual had identified this and was taking action to address it.

● We observed staff acknowledged people when they entered a room, even when providing 1:1 support to someone else they would still acknowledge others and seemed alert to others. Established staff knew people well; they supported people to be involved in conversations by speaking about things they liked and acknowledged when they reacted to something said. Less experienced staff were observed asking the established staff questions when they weren't sure and the more experienced staff were alert to the support being provided by less experienced staff and proactively offered support to deescalate incidents where people were appearing to become distressed.

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

● Feedback from relatives was positive in relation to the caring attitude of staff and the actual delivery of care. Comments included, "There are some really good carers there … They are good at communicating

with him", "I think they are trying and appear to have [person's name's] best interests at heart" and "Staff are kind and caring. Nothing but good things about staff."

● Some relatives did feel some staff knew people better than others and it was dependent on who was working. For example, where there were agency staff working, they were not always as familiar to people and did not have the level of knowledge about people's preferences, support needs or communication preferences. Relatives mostly felt this had been improving recently but this was still a work in progress relatives were understanding of the provider's recruitment challenges and felt the provider was doing what they could.

● We saw some positive interactions between people and staff. Staff mostly spoke passionately about people.

● Care records contained reference to people's cultural and religious preferences.

Supporting people to express their views and be involved in making decisions about their care

● People, and those important to them, were supported to be involved in reviews, assessments and meetings with other professionals about their care.

● People had access to independent advocacy for support with specific issues.

● People were supported to maintain contact with those important to them. Relatives confirmed they were able to visit with no restrictions. However, some relatives told us that communication was not always consistent and it sometimes depended on which staff were. Some relatives felt communication could be improved. Comments included, "Communication needs to improve. I don't always know when [person's name] has gone to the doctors. I'm not kept notified as much as I would like" and "For us it is consistency with communication … it is not consistent and depends who is on ... [Person's name] likes knowing mum and dad know what he is doing … we use this information to talk about what he has been up to when on calls with him."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed 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; 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

- People did not always receive care that was planned, personalised or responsive to their needs. There was a lack of clear guidance and key information for staff to enable them to consistently deliver the right support to people.
- Care plans did not always reflect people's needs or strengths. Staff did not always have the information in how they should work with people to promote their independence or engage people in activities.
- Staff relied on sharing information verbally and we saw evidence of people being supported with inconsistent approaches. For example, we observed two different approaches from staff when supporting the same person with the same activity on different days. On one of the days communication was clear and consistent and the staff prepared all the items they required. On the second day we observed the communication was not as clear. We observed the person had to wait for a drink following the end of the activity and they started to become anxious waiting for the drink. There was no clear guidance available to staff to detail the approach and this resulted in inconsistent support for the person. This could increase the risk of harm to themselves and/or others if their anxiety or distress increases as a result.
- Care planning documentation did not always promote person centred care. For example, one person's care plan detailed there can be limits to what activities and tasks they can participate in due to their diagnoses. However, it doesn't detail how to positively support the person to optimise success of participation and what approach to take. This meant the person was at increased risk of not being supported to access activities meaningful to them or supported to maximise their independence.
- We observed activities being offered to people and people being able to choose whether they wanted to do the activity offered. For example, sensory play, walks and drives. The service had a large hydrotherapy pool on site which people were able to access when it was available (it was also available for hire by other people supported by the organisation).
- The nominated individual told us they were working on identifying new activities and opportunities for people to engage in meaningful activities and was an area of improvement for the service. This was supported by the feedback from relatives and staff who told us they felt activities and opportunities for engagement could be improved on. Comments from relatives included, "Activities? Not great at the moment but I know there are developments and they are working on this", "I think they could improve consistency of activities" and "No concerns at all but they could build in more positive activities." One staff member told us, "For them not doing much, especially being autistic because then they have no drive to get up in the morning and to get out of their room. I think it is time to start looking at these. Support them to take them out, not just drives, a structured one so they have something to look forward to do in the day."

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● We saw evidence of how some people had been supported to have information presented in their preferred communication method. We saw people being supported with their communication aids and some staff were observed supporting people with Makaton.
● People were supported with social stories which staff were able to create with support from the provider. Social stories are a social learning tool that supports the safe and meaningful exchange of information between autistic people and staff.

Improving care quality in response to complaints or concerns
● Relatives told us they knew who to speak to at the service if they had any concerns. Comments included, "Great communication with [nominated individual's name] … she gets back to me really quickly" and "There has been a recent change in manager and there was good communication about changes; I know who to go to."
● A complaints procedure was in place to make sure any concerns or complaints were responded to and investigated.

End of life care and support
● No people were reported to be on end of life at the time of this inspection. The provider had plans in place to sensitively discuss with people and those important to them about their wishes.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control and independence over their lives. Care was not always person-centred and the poor leadership by the provider did not ensure people led empowered lives.
- People did not receive consistent person centred care that was empowering, of a high-quality and achieved good outcomes. Significant improvements were needed. These have been reported on in more detail in the responsive domain of the report.
- While the building blended in with the local community; the lack of effective quality audits had meant the support provided was at risk of becoming a closed culture. A closed culture is one where people's needs are not placed at the heart of care practices and people not being involved in their support.
- There was a lack of leadership within the service. At the time of inspection there was not a registered manager in post. The previous registered manager left the service in November 2022 and had a period of absence prior to leaving. One staff member told us, "I think that this home could be really good I think the management structure is very bad and very poor."
- The nominated individual told us they had taken over the management responsibility with support from the deputy manager who was 'acting manager' until a new manager was established. However, at the start of the inspection the details were still being worked out by the nominated individual and deputy manager and they needed time to establish an effective way of working.

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 a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. Relatives confirmed they were kept informed and updated of big incidents. One relative told us, "They do tell me if something big happens."

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

- The provider's oversight and governance of the service was ineffective in identifying the serious concerns and failings in relation to the safety, quality and standard of the service as detailed in the safe and effective sections of this report.
- Systems and processes to monitor the service were not robust. This meant they were not always effective,

did not drive improvement and did not identify all of the issues we found at this inspection. Concerns were found with regards to deployment of sufficiently skilled and competent staff, recruitment processes, risks and risk management, accidents and incidents, the premises, person-centred care, medicines, consent and quality assurance.

● The provider had some audits and checklists in place. There were not always completed consistently or effectively. Where some actions had been identified, there was not always evidence of identified timescales for completion, evidence of any reviews and no entries recorded to evidence when the action had been completed.

● The provider had failed to recognise or investigate incidents to prevent reoccurrences.

● The provider failed to ensure records were accurate and up to date. For example, we saw care planning documentation contained out of date information or conflicting information which meant staff did not have easily accessible current information about people. In addition, some records relating to the management of the home were incomplete. Such as cleaning schedules and fire related records.

● We found the training matrix in place at the time of the inspection was not kept up to date. There was no evidence staff new to the service were supported to complete training in a timely manner and their progress tracked. One staff member had no dates recorded for 13 training courses and these were marked purple to denote they were a new starter. However, they had been employed by the service for over 10 months at the time of the inspection.

● We identified concerns in relation to poor record keeping. For example, in relation to cleaning schedules, staff signing sheets, ABC charts, accident and incidents, daily notes and staff allocation sheets. We could see no evidence these concerns had been identified by the management team and action taken to address them.

● The provider had not ensured the management team and staff understood the principles of good quality assurance. For example, incidents were not analysed and did not include lessons learnt to inform practice development. Information to enable monitoring was unreliable. For example, the lack of detail on records detailing incidents.

● The provider failed to follow some of their own guidance within their policies and procedures to ensure quality and safety. For example, the provider's recruitment policy and procedure.

The failure to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks and maintain accurate and complete records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided.

● Some relatives told us they felt communication could be improved by the provider. We have reported on this in more detail in the caring domain.

● Staff told us they did not feel valued or listened to. One staff member told us they did not like the 'lack of support and not being appreciated'. Some staff told us about suggestions they had made to manage risks but felt they had not been listened to. For example, one staff member told us, "We've suggested things for our safety. For example, walkie talkies so we can call for assistance … They've given various reasons as to why not … We did have these buttons which were ridiculous as didn't work. We raised it wasn't working … for months we've been asking for the walkie talkies as a team."

● There had been some changes within the service following the manager leaving. Staff consistently told us they hadn't been kept updated about the changes and did not feel supported; they told us they felt the provider wasn't being open and honest with the staff team. Comments included, "We're just a bit confused

… We haven't been told anything, just that the manager has left", "No memo has been put out, no communication. We don't really know what the plan is … We found out through word of mouth and haven't even been told if they are hiring anyone", "I don't think there is much support from management at all" and "I've not felt supported at all."

● Systems and processes were not in place to ensure staff had access to appropriate support, supervision and appraisal. At the time of the inspection the deputy manager was in the process of addressing these concerns; they had scheduled supervisions for staff and probationary meetings. The nominated individual had scheduled a team meeting.

Working in partnership with others

● The service worked in partnership with health and social professionals. One relative told us, "[Person's name] has OTs and other outside professionals involved so they have engaged in trying to source other medical professionals' input. Where recommendations have been made by the professionals, The Firefly Club appear to be embracing this."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure care and support was appropriate to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises and equipment was properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to follow safe recruitment procedures.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 assess and do all that is reasonably practicable to mitigate risks to people and to ensure safe management of medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks and maintain accurate and complete records.

The enforcement action we took:

Warning notice

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

The enforcement action we took:

Warning notice