Leonard Cheshire Disability

Fethneys Living Options - Care Home Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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
Fethneys Living Options – Care Home Physical Disabilities is a residential care home providing personal care to 10 people at the time of the inspection. The service can support up to 10 people with a physical disability such as cerebral palsy; some people also had a learning disability; people used verbal communication. Their physical needs were supported in an adapted building, with a lift, overhead tracking hoists and accessible outdoor space.

People's experience of using this service and what we found
Right Support: People did not always receive personalised care that met their preferences, and people were not offered enough opportunities to enable them to live the lives they chose. For example, the high use of agency staff at the home meant people could not always go out when they wanted to. Two people wanted to go swimming, but there were no specifically trained staff to ensure safety when swimming. The home had an accessible minibus, but no staff were qualified to drive it, so people could not go out unless they hired accessible transport. People were not supported with their independence. For example, one person had a standing frame, but their relative said they had never seen them using it. Another person did not receive physio support in line with the requirements of their care plan.

People were not always 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.

Right Care: People received support from staff who were kind and caring. However, care was not always person-led and staff were reactive to people's needs. One person used picture reference cards to help staff understand how they were feeling. However, these cards were tangled up on their wheelchair and could not be easily reached by the person to use. Staff asked one person what they would like to do in the morning, colouring or sand play, but gave the person no time to respond. A staff member sat down and started to make moulds with the sand, but the person made it very clear they did not want to do this, delivering a strong, negative, verbal response.

Right Culture: People lived with a range of physical disabilities, and some had a learning disability. Staff were understanding of people's care and support needs, but the culture of the home did not encourage people's independence, and focused on what they could not do, rather than enabling people to have fulfilling lives. A relative was concerned about their loved one's mental wellbeing because they did not have

enough to do or activities that were planned in line with their preferences. People were not empowered to have a good quality of life, were accepting of staff support, but had limited opportunities to do what they wanted in the wider community.

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

Rating at last inspection
The last rating for this service was good (published 8 March 2019).

Why we inspected
This inspection was prompted due to concerns received about monitoring of risks, such as constipation and bowel management, and safeguarding referrals made to the local authority. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fethneys Living Options – Care Home Physical Disabilities on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to unsafe care and treatment, the lack of person-centred care, and ineffective governance of the service at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Fethneys Living Options - Care Home Physical Disabilities

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
The inspection was undertaken by 2 inspectors.

Service and service type
Fethneys Living Options – Care Home Physical Disabilities 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. Fethneys Living Options – Care Home Physical Disabilities 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 19 October 2023 and ended on 27 October 2023. We visited the location's service on 19 October 2023.

What we did before the inspection
We reviewed information we had received about the service, including safeguarding concerns we had been informed of which were being investigated by the local safeguarding authority. 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 used all this information to plan our inspection.

During the inspection
We spoke with the provider's interim service manager, registered manager, deputy manager, administrator, 5 care staff (including 2 agency staff), 5 people and 4 relatives. We reviewed a range of records including staff recruitment, 3 care plans, risk assessments and audits.

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

Systems and processes to safeguard people from the risk of abuse; assessing risk, safety monitoring and management

- People were not protected from known risks.
- Staff did not follow support plans from the physiotherapist putting a person at risk of harm. This person needed physio and was assessed by a physiotherapist initially in May 2021. A physio plan was written for care staff to follow, but this was not incorporated into the person's care plan. They did not receive support from care staff to support their mobility needs between 2021 and 2023. The physio plan advised the person needed to do stretches daily and support from staff 3 times a week to do some walking. According to records we reviewed the person's physio plan was not followed by staff. For example, in October, over a 3 week period, only 3 events were recorded by staff, indicating 'physio' had taken place. There was no detail as to what physio support had been provided. Over time, the person's mobility had deteriorated due to the lack of physio support. The person's relative told us they knew staff were not encouraging their family member to use their walking sticks as they were in the same position whenever they visited.
- We observed 1 person, sat in their wheelchair, was offered drinks on the morning of our inspection. At approximately 10.00 hrs, a large glass of squash (approximately 1 pint) was left by the person. This drink was left untouched until 13.15 hrs, when the person's relative took the drink away; the person was unable to reach the drink and had not been supported by staff to drink it. Staff had recorded this person's fluid intake as approximately 1,200 ml during the morning from 09.00 hrs until 13.00 hrs. This was not accurate. We saw the person had actually drank approximately 175 ml in total during this time. This put the person at risk of dehydration and the risk of constipation.
- People's risks were identified and assessed appropriately, with guidance for staff to follow. However, actions with regard to the mitigation of risks were not always taken. Agency staff were not always knowledgeable about people's risks or how to manage these. We asked one agency staff member how they would support people with epilepsy, but they did not know which people lived with this condition. Another agency staff member told us, "I can read information about people or I can ask staff; it's better to ask staff."
- The management team were aware that some monitoring forms for people had not always been completed when needed, but did not know information was not always accurately recorded. For example, fluid monitoring forms for one person showed a total consumption of 800 ml for one day and 600 ml another day. These totals were below those recommended by the NHS of 1,200 ml per day, yet no action was taken to reduce known risks of constipation which had resulted in admission to hospital on occasion for this person.

Risks to people were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● With regard to fluid intake, we discussed our concerns with the management team who told us they were aware of monitoring charts not being completed accurately by staff, but were unaware false information was being recorded. This would be addressed with the staff concerned.
● Staff completed safeguarding training. The registered manager said, "If I felt there was a risk of harm or abuse I would immediately notify safeguarding. Anything that goes to safeguarding goes to CQC also."
● We reviewed a range of people's risk assessments relating to bowel management, continence care, moving and handling, seizures, and food and fluid monitoring. These provided detailed information about people and how staff should support them.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● A person had been assessed by a speech and language therapist (SaLT) because of dysphagia (difficulty swallowing) and risk of choking. The SaLT had recommended the person receive a modified diet to mitigate their risk of choking, and receive food that was minced or chopped very small, and moist. The person chose not to follow this advice and had experienced 2 choking episodes because they had eaten high risk foods. Their capacity to make this decision had been assessed, and it was documented that they did understand the risks.
● We reviewed daily notes regarding this person's food intake and they consistently chose to eat high risk foods. When we asked the management team about this, they told us they had explained the risks to the person, but it was their choice.
● Reducing this risk could be better managed if records showed what food the person was offered, including low risk options, rather than just recording what they had eaten. This would demonstrate that alternatives had been available for the person to make an informed choice and potentially reduce the risk of choking.

We recommend the provider seeks advice and guidance from a health professional, such as a SaLT or dietician with regard to the consequences of unwise choices and steps they might take to reduce this person's risk of choking.

Preventing and controlling infection
● Some staff were not following the provider's Employee Handbook (March 2021) to ensure hand hygiene techniques were followed effectively to prevent the risk of infection to people. The provider's handbook states, 'Finger nails need to be short, clean and free of nail polish or false nails (this includes acrylic nails and any type of nail extension)'. We observed some staff had painted, long nails which would have been a barrier to effective, hygienic hand washing.
● The service was preventing visitors from catching and spreading infections.
● The service was supporting people living at the service to minimise the spread of infection.
● The service was admitting people safely to the service.

● The service was using PPE effectively and safely.
● The service was responding effectively to risks and signs of infection.
● The service was promoting safety through the layout and hygiene practices of the premises.
● The service was making sure infection outbreaks can be effectively prevented or managed.
● The service's infection prevention and control policy was up to date.

Visiting in care homes
People could receive visits from their relatives and friends; visitors were welcomed into the home. Hand sanitisers were available for them to use. The provider had a visitors' policy and advice on how to manage visitors during any infectious outbreak such as COVID-19.

Staffing and recruitment
● There were sufficient numbers of staff on duty. However, on occasion, there were not enough staff to enable people to go out when they wanted to. A relative said, "[Named family member] does not go out enough and the local authority has complained she is not getting the support she is funded for. If there's not enough staff, then sometimes people are not able to go out." Another relative told us, "There are no staff who are qualified to drive the minibus, and [named family member] has activities a bit further away, but she hasn't been able to do these because there is no-one to take her. It really depends. Sometimes I visit and there is an awful lot of staff, but some don't seem to know what they're doing; I think they're agency staff." People and their relatives told us that staff working weekends were predominantly provided by a care agency; they did not feel agency staff knew people well or how they wished to be supported. The management team told us there was always at least 1 permanent member of staff on duty at weekends working alongside agency staff.
● New staff were recruited safely and their employment histories were checked, their qualifications, and their suitability to work in a care setting. Disclosure and Barring Service (DBS) checks had been obtained. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were managed safely.
● Some people were given their medicines at lunchtime. This was done safely and sensitively by the staff member. The staff member washed their hands and changed their disposable gloves between administering medicines to each person.
● Medicines were stored securely in cupboards in people's bedrooms.
● Stocks of medicines were stored in a dedicated medicines room. People received their medicines as prescribed.
● Audits monitored all aspects of medicines management and were effective.

Learning lessons when things go wrong
● Lessons were learned if mistakes had been identified.
● The registered manager talked about medication errors that had occurred and said, "We had a few medication errors. There were gaps in reporting and with staff training. There was an incident where a person did not get their medicines so we organised training for staff. We talked about what forms we need to complete when an error occurs and who to inform. It was helpful to explain to staff the whole process as this helps them to understand more."

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained 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

● People's care was not always personalised in a way that resulted in positive outcomes. We observed staff were reactive rather than proactive when supporting people. One person expressed their concerns about the high use of agency staff, especially at weekends. They explained they preferred to be supported by staff who knew them well, but this was not always the case. The person added this could be frustrating, and they would have to direct staff on the way they liked personal care to be delivered. Agency staff sometimes asked this person about another person at the home and how they should support them.

● At inspection, we observed a member of care staff supporting a person with their lunch. The staff member was standing over the person and was not engaging with them, but having a conversation with a relative who was visiting their loved one. This was disrespectful and inappropriate and did not make for an enjoyable lunchtime experience for this person. We fed this back to the management team.

● Two relatives felt their family members did not have enough to do. People going out were reliant on there being sufficient staff available to support them and on transport. An external company could be sourced to provide accessible transport, but this had to be planned in advance; similarly with the use of public transport. People could not necessarily go out when they wished. Two people enjoyed swimming, but had not enjoyed this activity for several months, if at all, as they were unable to get to the pool without transport or staff support.

● On the provider's website, it states, 'We believe disabled people should have the freedom to live their lives the way they choose and every day we support this to happen.' People could not always choose what they wanted to do due to staff availability. Some activities were available for people to participate in, but this depended on staff being freed up to support them if they wished to go out.

● One person told us, "I can't go out at a weekend because the staff on duty either can't drive or don't know me well enough to go further than the end of the road."

People did not receive person-centred care that reflected their preferences and wishes. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● In response to the restrictions placed on people with regard to going out and participating in activities they were interested in, the registered manager said, "The staff really care about the people who live here and I know they get frustrated when the guys miss out on social activities. It can happen, dips and troughs. We've done massive work to improve that and I like to think I have quite a good relationship with people

who live here, I like to think that."

Continuous learning and improving care

● Safeguarding concerns had been raised with the local authority and actions taken by the management team to make improvements relating to these incidents.

● Overall, issues found at this inspection had not been identified through the provider's auditing systems. One person was not receiving physio support as identified in their care plan. Management oversight of how staff supported people in communal areas of the home was lacking. People did not receive personalised care or have many opportunities to access activities or interests in line with their preferences.

● Confidential information about people, such as hospital appointments and people's finances, were left in open pigeon holes in the sitting room. Time sheets, and documentation relating to staff, had also been left in these pigeon holes. An appointment book containing details of people's appointments at hospital for example, had been left in the dining room. Information about people's activities, including 1 person's wish to pursue online dating, were on display on the hall noticeboard for anyone to view.

● Not all information was available in an accessible format. Although we were told the majority of people could read, 'how to make a complaint' was not transcribed into easy-read format for people to easily understand.

● The management team were aware that some monitoring forms for people had not always been completed when needed, but did not know information was not always accurately recorded. For example, fluid monitoring forms for one person showed a total consumption of 800 ml for one day and 600 ml another day. These totals were below those recommended by the NHS of 1,200 ml per day, yet no action was taken to reduce known risks of constipation which had resulted in admission to hospital on occasion for this person.

● Based on our review of care records and risk assessments, we could not be assured that the management team, or staff delivering personal care, fully understood people's care needs or how to support them.

Governance systems were not sufficiently robust to identify areas for improvement to enable actions to be taken. Some personal information about people was not kept confidentially. This is 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

● People were encouraged to be involved in the service, and house meetings took place. The last meeting took place in September 2023, although only attended by 3 people, and people were asked if they would like to be involved in baking, bowling and to go out on a Thursday night. People confirmed these activities were of interest to them. One person felt that communication had improved lately, whereas they had felt ignored when raising a concern previously. They added, "Meals are okay, we get fed, it depends on who is cooking as to the quality." We saw people were not involved in food preparation, but observed staff preparing their lunch and supper for them.

● Relatives spoke positively of the current management arrangements, but expressed concern once the interim service manager left. A relative said, "I have no confidence in management after this staff member leaves. One manager has been off a lot, and I do feel sometimes staff are put first before people. If I ring the manager, she won't always answer. I often see staff sitting down in the lounge rather than attending to residents. The lounge is for residents, but it seems to be staff who use it, especially for tea breaks. This means residents are often sat in the dining room without a change of scene. When we bring [named family member] home for the weekend, she doesn't want to come back to Fethneys."

● Relatives were asked for their feedback about the home through a family questionnaire which was sent out in May 2023, but only one response was received.

● Staff told us they had a good knowledge of people's support needs and understood person-centred care. One person had been involved in the recruitment of staff. There was no evidence at inspection to demonstrate how people were encouraged with their independence, and engagement with people was predominantly task-led.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities under duty of candour and told us, "It's my responsibility to be open and transparent with the people that we support, with families, with external professionals, notifying CQC or any changes or disruption to service, notifications of abuse, etc. It's about honest and open conversations with safeguarding local professionals."

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

● The registered manager understood regulatory requirements and submitted notifications to CQC in line with statutory requirements. The registered manager had received the support of an interim service manager over recent months. The registered manager said, "It is quite a demanding service and there's a lot of work to be done across the 3 locations. [Named interim service manager] was brought in to work on the compliance side of things, but she leaves soon." All care plans were in the process of being reviewed.

● A staff member confirmed they had received supervision from the interim service manager since they commenced employment and felt supported in their role. Staff meetings took place every month and records confirmed this. Actions arising from these meetings were followed-up.

Working in partnership with others

● The management team worked with a range of health and social care professionals. People were funded for their care by local authorities. The registered manager told us they worked with a range of healthcare professionals. A physiotherapist who was employed at one of the provider's other homes had provided support previously.

● The registered manager was a member of various local fora and social media, engaging with other managers from care settings.

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 People did not receive person-centred care that reflected their preferences and wishes. Regulation 9 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed safely. Regulation 12 (1) (2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not sufficiently robust to identify areas for improvement to enable actions to be taken. Some personal information about people was not kept confidentially. Regulation 17 (1) (2)