Fairfield House Healthcare Limited

Fairfield House Residential Care Home

Inspection report

Fairfield House
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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

About the service
Fairfield House Residential Care Home is a residential care home providing accommodation for persons who require nursing or personal care to up to 36 people. The service provides support to older people, older people with physical disabilities and older people living with dementia. At the time of our inspection there were 28 people using the service. Fairfield House Residential Care Home has a main house split across two floors accessible by a lift or stairs. The grounds also contained separate cottages where people lived.

People's experience of using this service and what we found
At the time of our inspection Fairfield House Residential home was going through a period of transition. With a recent change of managers, the home had been inconsistently led and this had impacted on some of the systems and processes needed to ensure people were consistently safe and had their care needs identified and met.

Staff knew people well, we received feedback such as, "The staff are very pleasant I don't think you would get much better attention anywhere else." However, systems were not robust to ensure risks to people had been identified, managed, and reduced to protect people from the risk of harm.

Staff did not always feel proud to work at the home, did not always feel listened to and appreciated. Inconsistencies in leadership had led to staff not always being clear on managers' and other staff roles and responsibilities.

Recruitment files were not always fully completed to show people had been recruited safely into the service and governance systems failed to identify this.

Whilst some areas had improved since our last inspection, we found not all risks to people's health, safety and wellbeing had been considered to keep them safe from harm. Provider oversight of the home had improved since our last inspection; however, the home's governance had been inconsistent and had failed to identify areas requiring improvement we found at this inspection.

Healthcare professionals told us managers had not always listened to their advice however, had a good relationship with the home and the staff who provided care to people.

Staff knew how to safeguard people from abuse. The home used a dependency tool to ensure there were enough staff to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us they felt safe, had good relationships with the staff and enjoyed living at Fairfield House Residential Home. One person said, "It is very nice here."

Medicines were managed and administered safely by staff who had training and were signed off as competent to do so. The home was clean, and staff wore appropriate personal protective equipment (PPE) to prevent the spread of infection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 March 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to follow up on the breaches of regulation from the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
We carried out an unannounced focused inspection of this service on 15 December 2021. Two breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
You can read the report from our last focused inspection, by selecting the 'all reports' link for Fairfield House Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the safe care and treatment and good governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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.

Fairfield House Residential 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
The inspection was carried out by 2 inspectors.

Service and service type
Fairfield House Residential Care Home 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. Fairfield House Residential Care Home 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 a manager was running the home and had applied to Care Quality Commission

(CQC) to become the registered manager. This manager left before our inspection ended. The provider told us, another manager had been appointed to run the home. At the time of our inspection, they had not started an application to be registered with the CQC.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 4 May 2023 and ended on 12 May 2023. We visited the home on 4 May 2023 and 11 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 10 people who used the service and 4 relatives about their experience of the care provided. We received written feedback from 6 relatives.
We spoke with 6 members of staff and received written feedback from 13 staff including the owner/provider, nominated individual, area manager, deputy manager, senior care lead, senior care staff, housekeeping, kitchen and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received feedback from health professionals who work closely with the home.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at 5 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 requires improvement. The rating for this key question has remained 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- At our last inspection we found people had not always been protected because risks to them were not sufficiently assessed. At this inspection we found not enough improvement had been made and people had not always been protected from avoidable harm.
- People had been placed at risk of dehydration. Systems were not robust to monitor and assess the risks to 3 people who had been placed on fluid intake and output charts. Records showed days where people had only been offered fluids between 9am and 2pm, had only received 50mls of fluid and had no record of their output which 2 people required to monitor for urine retention.
- Concerns had not been identified by staff for healthcare professional input and staff had not been provided with instructions to monitor relevant people for signs and symptoms of dehydration or urine retention.
- Systems to prevent skin breakdown were not robust. People who required specialist equipment to prevent skin breakdown had been placed at risk of harm due to their equipment not being set at the right setting to be effective.
- Repositioning records showed people had not been repositioned according to their care plan. This meant people had stayed in 1 position for a length of time that could cause pressure sores and had placed them at risk of harm.
- A healthcare professional told us the home had not always followed their instructions to prevent the risk of skin deterioration. A member of staff explained why this had happened and told us the instructions had now been implemented.
- Where people had been prescribed high risk anticoagulant (blood thinning) medicines, risks to their health, safety and welfare had not always been assessed. Staff had not been provided with instructions to reduce the risk of any potential harm to the person.
- Risks posed to people due to their environment had not always been assessed. This included stairs which people could use to move between the ground and first floor.
- Risks to people's health, safety and well-being of acquiring an infection had not always been assessed including how susceptible they were and any risks that the environment and other people may pose to them.
- Whilst some improvements had been made since our last inspection to ensure accidents and incidents were reviewed monthly to identify any themes and trends, lessons had not been learned and embedded from our previous inspection and this had led to shortfalls during this inspection.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and

welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We discussed our concerns with the provider and area manager who told us they would review every person's care plan and told us a new computer system was coming into effect 1 June 2023. They told us this would improve how they identified and reduced the risks of harm to people.
● We shared our concerns with the local safeguarding team who are working with the service to ensure people are safe.

Staffing and recruitment
● Staff had been recruited safely into the service. However, some checks had not always been fully completed. For example, staff had not always been asked to complete health questionnaires regarding their fitness to work and gaps in employment history had not always been explored.
● Appropriate Disclosure and Barring Service (DBS) checks had been made. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The home used a dependency tool to ensure there were enough staff to meet people's needs. We observed staff were able to assist people with their needs and answer call bells in a timely manner. We received mixed feedback from people and relatives. Comments included: "Fairfield never appear to be lacking staff - there has always been someone available if I have needed any help during a visit", "I don't think the staffing levels are high enough" and, "I think they are a bit short staffed."

Systems and processes to safeguard people from the risk of abuse
● People were consistently safe from the risk of abuse. Staff had received training and knew how to recognise signs and symptoms of abuse.
● Staff knew who to report concerns to both within the home and who to report to outside the home if they felt their concerns were not listened to.
● The service had followed local safeguarding arrangements and safeguarding referrals had been made appropriately to the local authority.
● People and relatives told us they felt safe. One person said, "Yes I'm safe, they look after me well."

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.

Using medicines safely

● Medicines were managed safely. There were safe processes for the ordering, storage and disposal of medicines.

● Staff responsible for medicines were trained and had their competency assessed.

● Where people had medicines, they took when required, guidance was in place to ensure staff gave them when needed.

● Medicines that required stricter controls by law were kept secure and accurate records maintained.

Preventing and controlling infection

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

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

● 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 promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● At the time of our inspection there were no visiting restrictions which was in line with current government guidance.

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. The rating for this key question 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- At our last inspection we found a lack of oversight and governance to ensure a quality service. At this inspection, whilst the provider had improved their oversight, audits were either not in place or effective at identifying shortfalls found during this inspection.
- Systems and processes were either not effective or robust to ensure people were protected from potential harm. Systems had not always identified risks to people and systems to protect people had not always been followed, this had led to people being placed at risk of skin breakdown and dehydration.
- Audits were either not in place or effective at identifying shortfalls found during our inspection. A medication audit had been completed in March and April 2023, this had failed to identify people taking high risk medicines did not have risk assessments and care plans in place to manage any potential risk of taking a blood thinning medicine. An infection control audit completed March 2023 had failed to identify people did not have risk assessments to identify their risk of infections.
- The home did not have robust systems and processes in place to identify when staff recruitment files had not been fully completed, when care plans had not been reviewed and when records had not been completed for example, mental capacity assessments to demonstrate people had been supported to make their own decisions or when not able to, that decisions had been made which were the least restrictive and in their best interest.
- Robust systems were not always in place to improve the quality and safety of the service. Meeting minutes from a health and safety meeting in February 2023 showed us concerns had been raised to the manager in post at the time about the call bell system not working effectively and sensors being at risk of not working. We asked what had been done about this however, staff were not aware and could not tell us if the call bell system was now working. This had placed people at risk of not having their needs met.
- Records relating to the care and treatment of people were not always contemporaneous, up to date and fit for purpose. Welfare charts including food, fluid and repositioning charts were centrally located and not immediately accessible by staff delivering care. This meant staff would only complete the required paperwork at certain points during the day and not at point of care delivery. Records had gaps and were not completed fully which posed a risk that they were either not effective records reflective of the care delivered to the person or showed care was not being delivered as per their care plan.
- The provider did not always respond in a timely manner to feedback from people. During the first day of our inspection, we spoke with people who told us they were unhappy with 1 or 2 care staff who were either

heavy handed or washed them with tepid water. We feedback these comments and requested the manager or provider speak with people to gather their views. The provider did not speak to the 1 person who had consented for us to share their name, this meant we had to follow up at our next visit a week later.
● At the time of our inspection a manager was running the home and had applied to Care Quality Commission (CQC) to become the registered manager. This manager left before our inspection ended. The provider told us, another manager had been appointed to run the home. At the time of our inspection, they had not started an application to be registered with the CQC.
● Staff told us, due to the changes in management and inconsistency in leadership they were not certain who was responsible for certain tasks and what was expected of them in their job roles.
● Staff told us a manager who left during our inspection had not passed over information to ensure continuous learning and improving care.

At our last inspection the provider had failed to have good governance of the home, and this had placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Since our inspection the provider and area manager have been working on the areas identified during the inspection. We received information detailing actions taken so far including a review of risk assessments, mental capacity assessments, quality assurance reviews and have spoken to people to gather their views about the service. The call bell system was checked, and we received assurances this was working effectively, and the provider is arranging for an upgrade to the system.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff provided mixed feedback when asked if they were proud to work at Fairfield Residential Care Home. Comments from staff included: "I am proud of working here as I love working with our residents and providing the best possible care to them. I just wish we were able to have the staffing levels to give more to them", "I used to feel very proud to work at Fairfield, not so much now. I still hold out hope that one day things can be good at Fairfield again" and, "Yes I am proud as I love my job and the residents, I just feel unable to be empowered to correctly meet their needs."
● Some staff and relatives and told us they had not felt able to speak to the manager who had been running the service but told us they felt able to be open with senior staff and felt listened to. We received positive feedback about the deputy manager, the care lead and the care staff.
● We receive positive feedback about the appointment of an area manager who had been supporting the home since February 2023. Staff and people living in the home told us they felt able to speak with them and felt listened to.

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
● Relatives told us they were contacted by senior staff when things went wrong and found them to be open and honest.

Working in partnership with others
● Fairfield Residential Care Home had a good reputation within the community. The senior staff told us they were proud of the working relationship they had with professionals who supported them to provide care to

people.

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 Systems were not robust to ensure risks to people had been identified, managed, and reduced to protect people from the risk of harm.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were either not effective or robust to ensure people received safe, effective, caring and responsive care and people had been placed at risk of harm.

The enforcement action we took:

We issued a warning notice