Fairways Residential Home Limited

Fairways

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

This unannounced inspection took place on 09 January and 13 January 2017.

Fairways is registered to provide care and accommodation for up to 24 older people living with dementia. The home cares for people who require personal care and is made up of single and double rooms. Care is provided on a 24 hour basis. There is a lift to access all three floors of the building. The home is situated in the village of Heysham. At the time of the inspection visit 24 people lived at the home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in January 2016. At this inspection we found the service was not meeting the required fundamental standards. We identified breaches to Regulations 12, 13, 17 and 19 of the Health and Social Care Act, (2008) Regulated Activities 2014, as care and treatment was not always safe, recruitment checks were not consistently applied to new employees and paperwork was not always accurate and up to date.

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

We used this inspection carried out in January 2017 to ensure action had been taken to ensure all fundamental standards were now being met. We also carried out the comprehensive inspection to review the rating of the service.

At this inspection visit, we found some but not all improvements had been made. Improvements had been made that ensured systems were in place to notify the Care Quality Commission of incidents of abuse. The registered manager had implemented a new reporting system to ensure all concerns were reported to the appropriate bodies in a timely manner. However, the registered manager had failed to consistently notify the Commission of all other incidents in a timely manner. This was a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We looked at how risks were addressed and managed by the service. We found some improvements had been made to ensure people at risk of malnourishment were appropriately supported. Documentation had been introduced to manage and mitigate any risk. We found that management of risk was not consistently applied throughout the service. When people were at high risk of falls we found risks were not safely managed. This placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We noted care records and risk assessments identified some risks to people's health and wellbeing. These provided staff with guidance as to how to keep a person safe. Due to the ineffective deployment of staffing these risk assessments were not consistently followed by staff. This placed people at risk of harm from naturally occurring risk. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at care records. We found paperwork was inaccurate, incomplete and missing. This meant falls were not appropriately managed and people were at risk of harm. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Applications had been made to the supervisory body to deprive people of their liberty; however not all restrictions had been considered and documented upon the applications. This meant that two people were being unlawfully deprived of their liberty. Staff had some understanding of the Mental Capacity Act 2005 (MCA) and the relevance to their work. However, mental capacity was not routinely assessed and good practice guidelines were not referred to when a person lacked capacity. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered manager was restricting people's liberty without lawful authority.

We looked at how medicines were managed by the service. We found good practice guidelines were not consistently followed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager had partly implemented an auditing system to monitor the administration of medicines and to monitor accidents and incidents. However, these audits were ineffective and had not identified some of the concerns we identified during the inspection process. This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered manager had failed to assess, monitor and improve the quality and safety of the services provided.

We looked at staffing levels and deployment of staff on shift. Staff told us staffing levels met the needs of the people. Our observations demonstrated that deployment of staffing was sometimes poor. We observed people having to wait to have their needs met. Oversight in communal areas to supervise people at risk of falls was not consistent and placed people at risk of harm. People who displayed behaviours which challenged were not supported as documented within their care plan. This was a breach of Regulation 18 of the Health and Social Care Act 2008) Regulated Activities (2014) as staff were not effectively deployed to meet people's needs.

People who lived at the home told us the living space was busy. We reviewed the communal areas where people spent their time during the day. We found these areas cramped. This hindered people's mobility and increased the risk of people falling. We looked at accidents and incidents and noted three accidents had occurred where people had fallen into equipment or other people. On the day of the inspection, we observed another accident taking place. This was a breach of Regulation 15 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered provider had not ensured premises were maintained and fit for purpose.

Although we observed some caring and positive interactions, we noted person centred care was not always carried out. People received care which did not suit their preferences or needs. This was a breach of Regulation 9 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered manager had not ensured person centred care was consistently provided.

Staff responsible for providing care and support had knowledge of safeguarding procedures and were aware of their responsibilities for reporting any concerns.

During the inspection visit we walked around the home to assess the standards of cleanliness. On the first day of the inspection we found equipment at the home was not always available to ensure suitable hand hygiene processes could be consistently followed by staff. We found dirty mops being stored in a communal bathroom area. In another bathroom we found a seal had come away from a bath leaving a dirty residue around the bathing area. We have made a recommendation about this.

We spoke with the registered manager to see how people's voices were heard. Good practice guidelines were not in place to ensure people who could not speak for themselves and had no relatives to speak for them had an independent voice. We have made a recommendation about this.

We looked at recruitment checks undertaken by the registered manager and found improvements had been made. We found the provider had followed safe practices in relation to the recruitment of new staff.

Systems were in place for managing people's dietary needs. We noted input from health specialists when people were at risk of malnutrition. Documentation was up-to-date to ensure people's dietary needs were managed effectively. We received mixed feedback from people who lived at the home about the quality of the food.

People who lived at the home and relatives spoke highly about the staff. Staff were described as caring and kind. We observed positive interactions between staff and people who lived at the home during the inspection visit. Caring relationships were sometimes hampered by ineffective deployment of staffing.

Staff told us Fairways was a good place to work. They told us training was good and said they felt supported within their role. From viewing training records and speaking to staff however, we noted that staff had not received all appropriate training to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Relatives told us they were happy with the service provided. They said the management team was approachable and they were confident if they had any concerns action would be taken.

Following the inspection visit we raised several safeguarding concerns relating to some of the people who lived at the home. We also consulted with the infection prevention and control team, the fire and rescue service and the clinical commissioning group safeguarding lead. We requested that immediate action was taken by the registered provider to address and mitigate the risks we had identified during the inspection process. We received written confirmation from the nominated individual and the registered manager that immediate action would be taken.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Deployment of staffing was not suitable to ensure people's needs were met.

Risk was not consistently identified and managed. Risk was not identified and managed, this left people vulnerable to harm.

Arrangements were in place for management of all medicines; however they were not consistently applied.

People who lived at the home and relatives told us people were safe. Processes were in place to protect people from abuse. Staff were aware of their responsibilities in responding to abuse.

The service had recruitment procedures to assess the suitability of staff.

Is the service effective?

Inadequate

The service was not effective.

Staff had some understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and the relevance to their work. This was not always consistently applied and people were being unlawfully detained at the home.

People's health needs were monitored and advice was sometimes sought from other health professionals, where appropriate. However, care plans were unclear and inconsistent.

Deployment of staffing at lunchtime hindered people's experience at lunchtime. We received mixed feedback about the standard of food on offer.

Staff praised the ongoing training and told us it allowed them to meet the individual needs of people they supported. However, we noted staff did not always have the skills to carry out their role effectively.

Is the service caring?

Requires Improvement

The service was sometimes caring.

People who lived at the home described staff as kind and caring.

Staff had a good understanding of each person in order to deliver person centred care. People's preferences, likes and dislikes had been discussed so staff could deliver personalised care. However, this was sometimes hindered by the deployment of staffing.

Staff treated people with patience, warmth and compassion and respected people's rights to privacy, dignity and independence.

Is the service responsive?

Requires Improvement

The service was sometimes responsive.

Improvements had started to ensure all records were person centred. However, provision of person centred care was sometimes hindered by the deployment of staffing.

Records showed people were sometimes involved in making decisions about what was important to them. However, people's care needs were not always responded to in a timely manner.

The service had a complaints system to ensure all complaints were addressed and investigated in a timely manner.

Is the service well-led?

Inadequate

The service was not well led.

Improvements had not been made to ensure all statutory notifications were made in a timely manner.

Auditing systems in place were ineffective. Risks were not routinely considered. Identified concerns were not acted upon in a timely manner.

Staff told us regular communication took place between management and staff as a means to promote continuity of care. However, we noted leadership was inconsistent.

Fairways

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 09 and 13 January 2017. The first day was unannounced.

On the first day, the inspection was carried out by one adult social care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The adult social care inspector visited alone on the second day to complete the inspection visit.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We spoke with the Local Authorities, Clinical Commissioning Groups responsible for commissioning care and the local Healthwatch team to check if they had any concerns.

We reviewed information held upon our database in regards to the service. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

Information was gathered from a variety of sources throughout the inspection process. We spoke with eight members of staff. This included the nominated individual, the registered manager, the cook, and five members of staff who provided direct care.

We spoke with eight people who lived at the home to seek their opinion of the service. Not everyone who lived at the home was able to speak with us due to living with dementia. We observed interactions between staff and people using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five relatives to see if they were satisfied with the care provided. We also spoke with one health professional who had links with the service.

To gather information, we looked at a variety of records. This included care plan files related to seven people who lived at the home. We also looked at medicine administration records related to people who received support from staff to administer their medicines.

We viewed recruitment files belonging to three staff members and other documentation which was relevant to the management of the service. This included health and safety certification, training records, team meeting minutes, medicines administration records, accidents and incidents records and findings from monthly audits.

We looked around the home in both communal and private areas to assess the environment to ensure it met the needs of people who lived there.

Inadequate

Is the service safe?

Our findings

People who lived at the home told us they felt safe. Feedback included, "[Staff] keep an eye on everybody. They help me with having a bath and they come round at night and see if you're all right." And, "Staff keep us safe; they lock the door and check the fire alarms."

Relatives told us they thought family members were safe at the home. They said they were assured the premises were secure which kept people safe. One relative said, "General security seems good." And, "[Relative] needs help with bathing or they would fall. We know they are safe with staff."

Although we received positive feedback from people who lived at the home and relatives during our inspection visit we identified concerns regarding the safety of people who lived at the home.

At the inspection visit carried out in January 2016, we identified a breach to Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) 2014 as risks were not consistently managed by the service. We found processes were not consistently implemented to ensure people at risk of falls and malnourishment were suitably supported.

At this inspection visit carried out in January 2017, we found systems had not been fully identified and implemented to ensure people at risk of falls were protected from harm. Following the inspection in January 2016, the registered manager had implemented a falls diary into individual care records for people at risk. This registered manager said this enabled falls to be tracked so action could be taken and referrals to health professionals could be made in a timely manner following a person having a number of falls. We looked at the falls diary and noted information from the falls diary was not audited and safety measures were not implemented when a person had repeated falls.

On the second day of the inspection visit we were made aware that one person had fallen the night previous. The person was waiting to see their doctor in regard to the injuries sustained following the fall. During our visit the person fell once more, causing further significant harm to the person. We looked at the records for this person and noted the person's care plan stated the person had variable mobility and required some assistance from staff when their mobility was poor.

We looked at the falls diary for the person and noted from records the person had fallen five times in three months. We looked at the corresponding accident and incident reports and noted there had been six reported falls, one of which had not been documented upon the falls record. There was no falls risk assessment within the person's file which assessed the risk and provided guidance as to how to manage the risk. This placed the person at risk of harm.

We observed one person at risk of falls walking continually across a wet floor. This person was unsupervised. We pointed this out to a member of staff; they mopped the area around the person and placed hazard signs on the floor. Once the staff member had mopped the floor they left the person unsupported in the area on the wet floor. This exposed the person to potential slips, trips and falls. We observed the person looking

confused and unable to orientate around the hazard signs and we summoned assistance for the person.

We observed one person being supported to manoeuvre from a wheelchair to her chair using a walking frame. The person was struggling to transfer. We looked at the walking frame which was being used for the person and noted from the name on the front of the frame it did not belong to the person. We highlighted this to the member of staff who apologised. On the second day of the inspection visit staff noticed the person was again sitting with someone else's walking frame in front of them. This frame was of a different height and placed the person at risk of harm as it was not suitable for their use.

We viewed a copy of the services generic risk assessment and procedure for the home. This stated it was policy to consult with the person's doctor for a referral to be made to the falls team once a person had fallen four times. This had not occurred. The registered manager said they consulted with the person's doctor when the person fell but could not confirm any referral had been made to the falls team. This meant falls were not being suitably managed for the person.

We looked at care records relating to another person who was identified at risk of falls. We noted the person had received a significant injury from a fall the previous day. This had required hospital treatment. When talking with the person we noted they had bruising to their face. Staff told us the person had also fallen earlier that week.

We looked at the falls diary for this person and saw the person had fallen nine times in seven weeks. We viewed accident and incident reports and noted a further two falls had not been recorded on the falls diary. This demonstrated that risks to the person had not been suitably managed to protect the person from harm. Despite the frequency of this occurring and staff being aware of these behaviours, staff had not put any controls in place to prevent this from re-occurring to protect the person. This placed the person at risk of on-going and avoidable harm.

Prior to the inspection visit taking place we requested information regarding accidents and incidents that had taken place. We reviewed the number of accidents and incidents which had occurred at the home over a six month period. We noted forty per cent of all accidents and incidents had occurred during the night shift. In December 2016, we spoke with the registered manager about the number of accidents and incidents that had occurred during the night to ensure action was being taken to reduce this risk. They told us they had audited the accidents and incidents and were in discussion with the nominated individual as to how to decrease the number of night time incidents. They confirmed they had started reviewing staffing levels and were looking at ways of being more responsive to people's needs. At the inspection visit we spoke with night staff who confirmed two extra staff had been deployed to start work at 7am rather than 8am. This meant extra staff had been deployed for one hour of the night shift. No other arrangements had been put in place to protect people from harm.

We asked staff who completed night shifts how they ensured people were safe during the night. We were informed by a staff member there was a listening device in place for one person to monitor their activity. No other controls had been put in place to protect the rest of people at risk of harm during the night.
This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered manager had failed to ensure suitable systems were in place to manage and address risk.

Prior to this inspection visit in January 2017, we received some information of concern in regards to staffing levels. We used this inspection visit to look at staffing levels to ensure they met the needs of the people who lived at the home. We looked at the staff rota and noted staffing levels were variable each day. Staffing levels

ranged from two to four staff providing direct care on each shift.

We spoke with people who lived at the home and asked them if they were happy with staffing levels. We received mixed feedback about this. Three of the five people we spoke with told us they had no concerns with staffing levels. However, one person told us, "They're short at times. Another person said, "Evening's a problem – you can't have a drink when it's the night staff on because they are so busy."

On the second day of the inspection visit we heard staff talking amongst themselves. Staff were overheard saying they did not have time to take their breaks that day. We spoke with staff about staffing levels. Staff said they felt staffing levels allowed them to routinely meet the needs of the people who lived at the home. One staff member said, "Staffing levels are alright. Sometimes we can be busy but this isn't constant. Sometimes on nights we can be busy and we don't always get all our jobs done."

We noted deployment of staffing was inconsistent and did not meet people's needs. On the first day of the inspection visit we observed interactions at lunchtime and noted three people were supported to sit at a dining table in their wheelchairs for over an hour before lunch was served. These people were left unsupported with nothing to keep them occupied. One of the people had to wait another hour after lunch was finished until they were supported to move from their wheelchair to a more comfortable chair with a pressure cushion. On the second day of the inspection visit we observed three people sitting in wheelchairs at a table for over an hour before breakfast was served. We observed people sat in a main lounge area. They waited over an hour and a half for breakfast to be prepared and ready. We overheard one person being told breakfast was about to be served. They said, "Good. I am gasping for a cup of tea." We spoke to the registered manager about staffing arrangements at breakfast time. They told us staff responsible for providing care were responsible for preparing breakfast. The cook did not start until 10am.

We saw one person had a care plan that identified the person at risk of harm when walking. In order to manage the risk, the care plan stated the person required support from staff to mobilise. The registered manager told us there was constant staff presence in communal areas during the day to manage this risk. However, we noted on three occasions this person standing up from chair and walking without assistance from staff as there were no staff present to support them with their mobility.

We reviewed records related to another person who lived at the home. From discussions previous to the inspection visit we were aware the person had some behaviours which challenged the service. The persons care plan stated the person was not to be left unattended in communal areas. During the inspection visit we observed the person being left unattended in the communal area on at least four occasions. This placed them at risk of harm. We asked the registered manager about processes. They confirmed staff were expected to have oversight of this person whilst they were in the communal area. This was not consistently applied.

We observed one person who was living with dementia walking around the home. On two occasions we had to intervene and seek assistance as this person was trying to eat inappropriate objects. There was no oversight of this person to ensure they were kept safe.

We looked at evacuation plans developed to assist staff in the event of an emergency. The registered manager had completed an evacuation plan for each person who lived at the home. Each evacuation plan stated that the home had a policy of not evacuating people in the event of the fire and people would be encouraged to stay put. We discussed these findings with the fire and rescue service and they confirmed this procedure was not in line with their policy. We noted should a fire break out during the night when two staff were on shift and a full evacuation of the building was required there was insufficient numbers of staff to carry out this out in a timely manner.

We spoke with the registered manager about deployment of staffing. They said it was difficult to deploy staff appropriately when they did not receive one to one funding for people. They told us the nominated individual decided on staffing levels. They confirmed no staffing dependency tools were used to assist them in planning suitable staffing levels.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulated Activities 2014 as staff were not effectively deployed to meet the needs of the people who lived at the home.

During this inspection visit, we looked at the arrangements for the management of medicines. We observed a senior carer giving people their medicines. They followed safe practices and treated people respectfully and were patient. We observed people being offered pain relief medicines to manage pain. We looked at systems for managing controlled drugs. Staff knew the required procedures for managing controlled drugs.

Although we observed some positive practice we found arrangements were not always safe. During the walk around the home we noted a prescribed cream was being stored in a communal bathroom. This was not secure.

We looked at guidance for the management of creams and ointments and noted they were not signed for upon the Medicines Administration Record Sheet. (MARS) We asked the registered manager about this and they advised that carers administered the creams and ticked a box to show they had done so on a daily diary sheet. However, the daily diary sheet did not specify which creams had been prescribed, by who and when. We also noted when creams and ointments were to be applied there was no guidance for staff as to which areas the creams and ointments were to be applied to. There was no information on the MAR sheet to give staff direction. The registered manager confirmed they did not have any body maps in place to support staff to show where prescribed creams had to be applied to. For medicines that staff administered as a patch, there was no system in place for recording the site of application. This was necessary because the application site needed to be rotated to prevent side effects.

This was a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014 (Safe Care and treatment) as suitable systems were not in place to ensure medicines were safely administered.

We asked people who lived at the home about the communal areas of the home. We received negative feedback including, "It's always busy in here." And, "You sit too much. It's impossible to get about so much because it's too crowded with people's walkers and the like. At home you're up and down doing things." Another person said, "What do you expect? It's a big business here. There are lots of people."

Observations over the two day period demonstrated the environment in the communal areas was cramped. For people who required the use of walking aids we noted access areas were often blocked. We observed one person having to move a coffee table out of the way so they could walk through an area. On another occasion, we observed a trolley carrying cleaning materials being pushed over a person's foot, because of this lack of space. We spoke to a staff member about the environment. They told us on one occasion they had observed a person who was at risk of falls having to lift their walking frame over another person's frame to get access.

We looked at accidents and incidents that had occurred at the home. We identified three accidents had occurred over a nine month period which had involved people falling into pieces of equipment or other people. We found no evidence to demonstrate these concerns had been identified and acted upon. The registered manager acknowledged the areas could be busy. They said they had tried using a lounge area upstairs to alleviate the issue of space but this had not worked.

During the inspection visit we noted risks within the environment were sometimes suitably managed. We saw window restrictors were in place which met the health and safety executive guidelines to prevent people from falling from height. Radiator covers were in place to minimise the risk of people being burned by hot surfaces.

During a walk around the building we saw four fire doors were wedged open. We discussed this with the registered manager they told us one person did this themselves but acknowledged staff must have wedged the other doors open. They told us they would take action immediately to address this. Following our inspection visit we spoke with the Fire and Rescue Service. They agreed to visit the home to review the service's fire procedures.

We spoke to the person responsible for maintenance of the home. We asked if they carried out at formal environmental audits. They confirmed they did not carry out audits. This meant that window restrictors in place and bedrails were not routinely checked to ensure they were safe and fit for purpose. We spoke with the registered manager they confirmed no other people carried out any formal audits of the environment.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) as the registered manager had failed to ensure the premises were suitable for the purpose for which they were being used.

As part of the inspection we looked at infection control systems in place at the home. The registered manager completed three quarterly infection control audits. Whilst these audits had not identified any concerns, we noted infection control procedures were not consistently addressed. Whilst observing medicines being administered we watched the staff member trying to use the hand dispenser pump to sanitise their hands. There was no hand gel in the pump. They confirmed it was empty and said they would ask the cleaner to fill it. The lack of gel meant the staff did not sanitise their hands before administering medicines.

On the first day of inspection we found a communal bathroom on the ground floor had no suitable hand washing facilities in place. We observed people independently using this bathroom throughout the inspection visit and observed staff supporting people to also use this bathroom. However, there were no paper towels in the bathroom for people to dry their hands with. We noted one communal towel in place. Communal towels can hold germs and spread infection between people. In the same bathroom we also found three cleaning mops and buckets being stored in a shower facility. This promoted a risk of cross infection. We found there were no waste bins in any bathrooms to aid with disposal of hand towels. In two bathrooms we found there were no toilet roll dispensers. Toilet rolls were left exposed on the radiator for usage. This placed people at risk of harm from cross infection. We saw one bath seal around the bottom of a bath panel and the floor had peeled away. This had left a dirt residue along the bath and posed an infection control risk as it could not be suitably cleaned. At the end of the first day we provided feedback to the registered manager regarding these concerns. On the second day of inspection we noted some improvements had been made to manage these risks but there were still some outstanding tasks. Waste bins were not in bathrooms and the seal around the bath had not been cleaned or replaced. Following the inspection visit we made a referral to the infection prevention and control team to carry out a full review of infection control procedures at the home.

At the inspection carried out in January 2016, we identified a breach to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure suitable systems were in place to check staff employed were suitable for working with vulnerable people.

At this inspection visit we found improvements had been made to recruitment procedures to ensure people were supported by suitably qualified and experienced staff. We reviewed three staff files. Full employment checks were carried out prior to staff starting work. Two references were sought and stored on file prior to an individual commencing work. One of which was the last employer. Gaps in employment history had been explored with each applicant. The service requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a statutory requirement for people providing a personal care service supporting vulnerable people. The service checked this documentation prior to confirming a person's employment.

We looked at how safeguarding procedures were managed by the service. We did this to ensure people were protected from any harm. Staff told us they had received safeguarding training. They were able to describe different forms of abuse and said they would report any concerns to management. One staff member said, "I would report it to the senior or the manager whoever was on shift."

We looked at documentation relating to the health and safety of the home. On the first day of inspection we viewed certification for electrical safety testing and fire equipment. The registered manager was unable to locate an up to date gas safety certificate or the legionella certificate. On the second day they advised us the maintenance person would be visiting the next week to carry out the required checks. Following the inspection visit we received confirmation these checks had taken place.

Inadequate

Is the service effective?

Our findings

At the inspection carried out in January 2016, we identified a breach to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to gain lawful authority to deprive people of their liberty. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection visit carried out in January 2017, we found some but not all improvements had been made. The registered manager had implemented a process that ensured when people were admitted to the home a DoLS application was completed. The registered manager routinely chased up the progress of applications as a means to track progress. DoLS applications were copied and stored for further reference. Although applications had been made we found these were not accurate and clear about which restrictions were in place.

During the walk around the home on the first day, we noted two stairgates were in use on two people's bedroom doors. We asked the registered manager about these and they explained they were in place to keep the people safe and prevent them from wandering onto the hall. This meant that people's freedom to move freely was being restricted. We looked at the care records for both these people and noted the stairgates were not documented within people's care records. Nor was there any evidence of best interest discussions being held to ensure decisions made were in the person's best interests.

We raised concerns with the registered manager during feedback on the first day of inspection. They confirmed the restrictions on the people's liberty were not recorded within the DoLS application. They told us they would review the process immediately. On the second day of the inspection visit we found one person's stair gate had been removed. The other person's stair gate was still on the door. We observed the person inside the room with the stair gate in situ. Following the inspection, we made a safeguarding alert to the local authority as the service was unlawfully restricting the liberty of people who lived at the home.

During discussions with staff as to how people were kept safe during the night, one staff member told us they used a listening device in one person's bedroom to monitor for any activity. We looked at the care plan for this person which stated the monitor would be used when the person was in their room. We found no evidence within the care records to show a best interests discussion had been held to arrive at this decision. The registered manager said they were in the process of talking with family to agree upon the course of action. They told us the monitor was not yet in use. This conflicted with what the records implied and what staff told us. On the second day of inspection, we looked in the person's room and noted the monitor was

on the side and had electrical power running to it. Following the inspection we made a safeguarding alert to the local authority as the service was unlawfully restricting the liberty of people who lived at the home.

At the last inspection carried out in January 2016, the registered provider agreed they would be more proactive with completing capacity assessments. They said they would start carrying out their own capacity assessments for each person where it was appropriate. This however had not happened. Care records maintained by the service failed to consistently address people's capacity and decision making. We noted capacity assessments were not carried out when people lacked capacity. Within the files we viewed we noted two people had not had their capacity assessed for any aspects of their care and support.

The registered manager told us if decisions were required in relation to people's health they would consult with the person's doctor and mental health team. They told us three people who lived in the home had lasting powers of attorney (LPA) that were responsible for managing people's finances. We observed on one occasion the registered manager had consulted with the LPA when a decision had been made by family that was not deemed in the persons best interests. The registered manager could not provide any evidence to show best interest meetings were consistently arranged for all people who lived at the home when decisions were to be made.

We asked a member of staff what their understanding of MCA was. The member of staff said they did not know what this meant and could not explain its meaning in relation to their work. We looked at a training matrix completed by the registered manager. This showed us staff had not received any training in regards to the Mental Capacity Act.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered manager had failed to ensure people being deprived of their liberty were done so lawfully.

We looked at how the service met people's dietary needs. At the inspection in January 2016, we noted that people at risk of malnutrition were not suitably supported. Weight charts and food and fluid charts for people had not been completed and therefore had not identified when people were at risk. At this inspection visit we noted some improvements had been made. For people at risk of malnutrition food and fluid charts had been implemented. People were weighed on a monthly basis and weights were recorded. We saw evidence of input from other health professionals when people were at risk of malnutrition.

We received mixed feedback from people who lived at the home and relatives about the quality and choice of meals provided. Feedback included, "They're okay – not so bad." And, "They're okay, but sometimes they're not warm enough." And, "If don't fancy something they'll ask 'what would you like?'" And, "They are plain but adequate but not always warm."

We observed meals being served at breakfast and lunchtime. Tables in the dining area were laid with two cloths, table mats and cutlery in advance of the meal. These were all clean and were removed after the meal for laundering. Some people were provided with aprons to protect their clothes. People's individual requirements had been assessed to promote their independence. For example, some food was served on plates or dishes with raised sides; some plates were red, to support people with visual and cognitive difficulties.

On both occasions people had to wait significant long periods for meals to be served. We were advised on the first day the wait was due to maintenance people being in the building. On the second day we were given no explanation as to why people had to wait. We noted staff on the morning shift were also

responsible for making peoples breakfasts. Breakfast was not prepared until most people were up and dressed. On the second day of inspection this was 9:30am.

There were three carers on duty, who took food to people in both the dining room and the other areas used including the main lounge area. Staff were responsible for both serving food and at the same time support those who needed it. This meant that oversight of people was inconsistent. One person's care plan stated the person required their food cutting up. This had not been done. We observed the person struggling to eat their food. A member of staff who was administering medicines intervened and offered support. Two people complained about the food not being warm enough when it was served so the staff returned it to the kitchen for re-heating.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) as the registered manager had not ensured staff were suitably deployed to meet the needs of people who lived at the home.

People who lived at the home told us they received effective care. Feedback included, "I've seen the doctor once, for a blood test." And, "I'm diabetic and they watch me like a hawk if I try to eat sweets. They say 'You're not supposed to.'"

One person who lived at the home told us their health had improved since they had moved into the home. They told us they were supported by staff to attend health appointments and were supported to exercise. They told us they hoped to return home when their health improved.

Relatives told us they were confident people's health needs were met and were happy with the way in which they were involved and communicated with. The registered manager spoke positively about the care provided at the home and could give examples of when people's health had improved. For example, one person had recently returned from the hospital for end of life care. This person's health needs had improved at the home and the person was removed from the end of life register.

We spoke with a health professional who was visiting the home to attend to the medical needs of some of the people who lived at the home. They said they had no concerns with the standard of care provided. They said there had been some previous concerns but staff had taken on board the information and advice offered and consequently standards of care had improved.

Although we received positive feedback about the ways in which the service managed people's health. We found care planning documentation was not always accurate, up to date and complete. Systems had been implemented and care plans had been reviewed on a quarterly basis, we found some of the information within the files was difficult to locate and understand. For example, one person's care plan stated the person's health needs had changed and they required hoisting but the moving and handling assessment for the person had not been reviewed and updated. This still referred to the person mobilising independently. The moving and handling record stated the assessment was to be reviewed following the person returning from hospital in October 2016 but the assessment had not been reviewed and completed. This could cause confusion for staff who do not know the person well.

Another person's care plan made no reference to a catheter but a review had taken place and the person had been fitted with a catheter. When discussed with the registered manager they explained the catheter had been fitted and then removed. There was no record to show when the decision had been taken to remove the catheter or who had made the decision. We also identified one person had a Do Not Resuscitate (DNAR) instruction within their file. This had expired nine days before the inspection. The registered

manager said they were waiting for a doctor to visit the home to review this, but this had not been done in a timely manner and had consequently expired.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered manager had failed to ensure an accurate and complete record was maintained for all people who lived at the home.

We looked at training to check staff were given the opportunity to develop skills to enable them to give effective care. Staff told us the training provided was good. One staff member said, "They are good like that (the managers) they will offer training. You can ask to be put on courses and they will tell you when training has expired." Another member of staff told us they were completing their care certificate. A care certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

We looked at a training matrix maintained by the management team and noted some training had been provided in first aid, food safety, health and safety, safeguarding of vulnerable adults. Only 9 of the 33 people named on the training matrix had received any fire training in the last twelve months. No staff had received any Mental Capacity training, this reflected in the documentation maintained at the home in regards to people's capacity and consent. We asked the registered manager if the training matrix was up to date. They told us it was up to date with completed training.

This was a Breach of Regulation18 of the Health and Social Care Act, (2008) Regulated Activities 2014 as the registered manager had not ensured that staff had received suitable training as was necessary to enable them to carry out their duties they were required to perform.

We spoke with a member of staff who had been recently employed to work within the service. They told us they undertook an induction period at the commencement of their employment. They said they undertook an induction with the registered manager and completed two weeks shadowing with other staff members. They said, "By the end of the two weeks I was confident in what I was doing."

We spoke with staff about supervision. Supervision is a one to one meeting between staff member and manager. The meetings are used to discuss performance and identify training needs. Staff said they received regular supervision. Staff said managers were approachable and they were not afraid to discuss any concerns they may have in between supervisions. This enabled staff to access further development opportunities if required. Staff told us they also had appraisals on a frequent basis.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home and relatives told us the staff were kind and caring. Feedback included, "They're very friendly, very nice." And, "You never hear a cross word from any of them. They are very nice." In addition, "They are very nice to everyone."

We observed some positive interactions with people during the inspection visit. We observed staff offering reassurance to a person when they were worried and confused. Staff demonstrated patience and empathy for the person and tried to provide them with information to enable them to stop worrying.

We noted staff responded when people were in need. We observed one staff member offering comfort to a person who was upset. The staff member provided the person with a tissue and offered them comfort. This was positively received by the person.

We observed staff supporting people to transfer between wheelchairs to chairs. Staff were patient and gave people clear instruction and reinforcement to enable people to feel safe. People were not rushed and were given the necessary time required.

Staff were aware of people's life histories. One person was showing signs of being confused. Staff took time to try and orientate the person by talking about the person and their life history. They spoke with the person about their family and the person's working career. This enabled the person to feel less confused and made them feel more assured.

We observed staff respecting people's right to privacy. We observed a health professional visiting the home. They explained they were busy and as such asked if people would be happy having their treatment downstairs with the use of a privacy screen. Staff asked people their views on this and respected people's decisions when they asked to be taken to the privacy of their own room. The health professional praised the staff and their attitude and said people were consistently asked their preferences for care.

Although staff displayed caring attitudes to the people they supported, we found insufficient deployment of staff sometimes hindered the caring relationship. On both days of the inspection visit we observed people being left alone without any stimulus or interaction.

We asked people who lived at the home about the relationships they had forged with staff. Three people who lived at the home told us sometimes staff did not have time to sit with them and talk. They said, "Sometimes they have time [to listen and chat. Sometimes there is something that needs their immediate attention. They'll explain why they haven't time." And, "They haven't got time [to listen and chat."

During the inspection visit we noted three people who lived in the home had no family or representatives. We spoke to the registered manager to assess how decisions were made for these people and to see if they had access to advocacy services. We were told no one at present used an advocacy service. This meant that people who lived at the home did not have consistent independent advice to support them with making

choices.

We recommend the registered manager refers to and implements good practice guidelines to support people without a voice to be heard.

Requires Improvement

Is the service responsive?

Our findings

We looked at care records related to seven people who lived at the home. We found not all improvements had been made. Care plans addressed a number of topics including managing health conditions, medicines administration, personal care, diet and nutrition needs and personal safety.

The registered manager told us they were in the process of improving paperwork at the home to make it more user friendly. We noted a new care planning document had been introduced in some but not all of the files. The new document provided more person centred information about each individual and covered people's preferences and choices.

We asked four people who lived at the home if they were involved in the planning of their care. None of them could remember being involved in the development of their care plan. They did tell us they were routinely involved in deciding on their care. Feedback included, "You get to choose your meals in advance and I get up and go to bed when I want." And, "Nobody's stopped me doing anything up to now!" Another person told us staff sometimes worked flexibly to meet people's needs. They said they could choose the staff member who worked with them. They told us they always received a female carer when they were being supported with personal care. This demonstrated that individualised care sometimes occurred.

Although records contained person centred information regarding each individual we noted that person centred care was not routinely carried out. One person had expressed a wish within their care plan to be called by their full name. We observed staff calling the person by a shortened version of their name. We spoke to the registered manager about this. They said the person had changed their mind and were happy to be referred to as the shortened version of their name. This was not documented anywhere. Another person had moved into the home two weeks ago. A member of staff started to read a book with the person. The person said they could not see without their glasses. The staff said they were not aware the person required glasses. They went to the persons' room and found a pair of glasses in their belongings. The registered manager confirmed this was recorded in the person's care plan but staff had not followed the care plan on this occasion.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as care being delivered was not consistently appropriate to meet the needs of the people who lived at the home.

We asked people who lived at the home about the variety of activities on offer. We received negative feedback about this. Comments included, "It's a long day sitting here." And, "That's the only trouble here. You sit too much. It gets a bit boring here." And, "There is not enough to do]. I can't read because of my eyesight but I talk to the other people and watch TV."

At the last inspection visit the registered provider said they were planning on recruiting for a new activities coordinator. We asked about this at this inspection visit. The nominated individual said they had tried to recruit but had been unsuccessful. We looked at the staff rota and noted no additional staff had been deployed to provide additional support to promote activities for people.

The registered manager said some activities had taken place over Christmas. People had been to the pantomime. We saw some arts and crafts were on display at the home that had been made for Christmas.

On the first day of the inspection visit we noted one member of staff took some time out to reminisce with people who lived at the home. Another member of staff supported one person to go out to visit a family member. No other activities took place. On the second day of the inspection we observed people being offered magazines to read. A staff member also spent a short period of time looking at a history book with one person who lived at the home. We noted this temporarily relieved the person's anxiety.

Apart from the complaints in regards to the food, people we spoke with said they had no complaints about current service provision. Feedback included, "I'd just tell whoever was there at the time." And, "I would just speak to one of the carers. If there was a senior carer, they'd be told." And "If there was a problem, I would speak to whoever was available."

Relatives also told us they had no complaints. Feedback included, "I have no concerns. I am more than happy." And, "They've got [person's] interests at heart. I can't fault the way they look after [person]." And, "What I see is all right."

Staff told us they were aware of the complaints procedure and would inform the registered manager if people complained.

We spoke to the Registered Manager about complaints. They said they had not received any formal complaints.

Inadequate

Is the service well-led?

Our findings

A manager was registered with the Care Quality Commission to manage Fairways in July 2016. People and relatives spoke highly of the new registered manager and their approachability. Feedback included, "[Registered manager] is very nice." And, "They are lovely." When asked, people and relatives were able to identify the registered manager in charge. Every person we spoke with considered the home as well-managed.

Although we received positive feedback about the management of the service we found management of the service was inconsistent and identified significant shortfalls in the ways in which the service was led. We found that not all improvements had been made as required from the inspection visit in January 2017 and not all fundamental standards had been met.

At the inspection visit carried out January 2016, we identified a breach to Regulation 18 of the Care Quality Commission (Registration) regulations as the registered provider had failed to report all notifiable events as stated within the regulations.

Following the January 2016 inspection we noted the registered manager had taken action and had started notifying us of relevant safeguarding incidents. However, at this inspection visit we identified two incidents which had occurred which had required police involvement. We did not receive both of these statutory notifications for these incidents. We spoke to the registered manager about reporting responsibilities. They were not aware of the need to notify us of police incidents. We received the requested notifications following the inspection visit as requested. This demonstrated however that the registered manager was not fully aware of their responsibilities.
Information was supplied reactively and not in a timely manner.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection visit we looked at auditing systems in place. We found quality assurance systems were poor. Medicines audits were taking place on a monthly basis and infection control audits took place on a quarterly basis. Although these audits had taken place we noted they were ineffective as they had not found the concerns we identified during the inspection visit. This placed people at risk of harm and ineffective care.

We asked the registered manager about care planning audits as we had identified some concerns within care records. The registered manager told us they completed an informal audit of care records but did not document this. We found care records in place still continued to be inaccurate and incomplete. Information held within records was missing and conflicting. This demonstrated that any systems for reviewing care records was ineffective and placed people at risk of poor care and harm.

We looked at the accidents and incidents audits. Although audits had taken place they were ineffective as

action had not been taken to fully address the risks identified within the audits. This meant that people who lived at the home were at risk of receiving poor and ineffective care.

No auditing systems were present to show that risks within the environment had been addressed and managed. This placed people at risk of harm.

This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered manager had failed to assess, monitor and improve the quality and safety of the services provided.

Following the inspection visit we raised our immediate concerns with the registered manager and requested immediate action was taken to promote people's safety within the home. We received an action plan from the registered manager to show that immediate action would be taken to address the risks we had identified during the inspection process. This included increasing staffing levels and referring people to the falls team.

The registered manager said staff retention was good. We noted people at the home were supported by a consistent staff team. Staff were supported through regular communication with the management team. Although there was support from the management team we noted leadership was not always consistent. Staff were not always aware of their responsibilities and care provided was not always in line with care plans or good practice guidelines.

Staff described communication within the service as good. Staff received a daily handover from staff who were finishing their shift. Handovers allow for information to be passed on to promote continuity of care. They told us they had the opportunity to talk with other staff and the management team at regular team meetings. We saw evidence of regular team meetings taking place.

Staff we spoke with also praised the skills of the registered manager and their approachability. Staff described a positive working culture, where teamwork was good and staff morale was good. One staff member said, "It's a good place to work. I worked in another home before coming here. This is much better. Staff really care."

We spoke to the registered manager about systems in place to seek people's views about the quality of the service. The registered manager told us they routinely asked relatives to complete questionnaires for feedback on the service when they visited. We viewed a sample of these and noted feedback on the service was positive.