Mavin [Care] Limited

Fairlawns Care Home

Inspection report

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11 March 2016

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Care Quality Commission (CQC) carried out a full comprehensive inspection on 20 August 2015 and rated the service overall as Inadequate, with the service being Inadequate in Safe, Effective, Responsive and Well-led, and Requires Improvement in Caring. This resulted in the service being put into special measures. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

You can read the report from our comprehensive inspection of 20 August 2015, by selecting the 'all reports' link for 'Fairlawns care Home' on our website at www.cqc.org.uk

This unannounced comprehensive inspection was carried out on the 10 and 11 March 2016. There was a serious lack of oversight from senior management who were failing to recognise and address poor standards. As a result people living in the service were at serious risk of not receiving the care and support they needed. We found no improvements had been made to the overall quality and safety of the service since our last inspection. At the end of the first day we fed back our concerns to the representative of the provider (a director) and the manager. We were given assurances that they took our concerns seriously and would take immediate action to address them.

However, the next day we received two separate serious concerns stating that people continued to be at risk and there was no managerial presence in the service. We were unable to contact the manager or provider to discuss these concerns so we returned to the service at 3.45pm. We found insufficient staff and people had not been given their morning medicines. We reported our concerns to the local authority, who arranged for an external care service to provide 24 hour support to existing staff specifically focussing on safe medicines administration. We took urgent action to restrict the service taking any new admissions. In addition an urgent condition was made for the provider to ensure there were systems in place for the safe oversight and management of medicines, provided by trained and competent staff.

Fairlawns Care Home provides accommodation and personal care for up to 19 older people, some living with dementia. There were nine people living in the service when we inspected on the 10 and 11 of March 2016.

There was not a registered manager in post. 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 manager had submitted an application to be registered with the Commission which was being processed.

The provider was failing to ensure that people were provided with a service that kept them safe and took prompt effective action to minimise risks. There were not enough suitability trained and competent staff to meet people's needs. This included the manager who did not have the skills to oversee medicine

management and did not recognise poor practice in general. The environment and equipment was not maintained to a safe level. The lift, washing machines and dryers were not working properly. People were not protected by the recruitment checks undertaken to ensure staff were of good character and had the required experience and skills to carry out their role.

The manager and director were unable to demonstrate that they and the staff had the skills and knowledge to provide people with care that was responsive to their needs.

People's nutritional needs were not being monitored effectively to ensure they had enough to eat. Where records showed people had lost weight, no action had been taken to seek health professional's advice and/or promote weight gain by offering nutritious snacks.

Improvements were needed in how people's ability to make decisions were assessed and recorded. The management of the service lacked a working knowledge of the recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS). Therefore they could not demonstrate any restrictions in place were lawful.

People and their relatives told us they were treated in a kind, friendly and respectful manner, but felt staff did not always have the time to sit and talk with them. People's personal information was not kept secure and confidential. The practice of drying people's clothing, including underwear, in the communal areas of the service, did not support people's dignity and respect.

People did not receive personalised care that was responsive to their needs. There was a lack of information about their health, social and emotional well-being. People were not always being provided and/or supported, to access activities and social contact which provided mental stimulation. This put them at risk of becoming socially isolated.

There was a poor culture in the service where staff felt they were not valued, listened to, or able to influence service improvement. The service's quality assurance system was not robust. It failed to independently identify shortfalls in the care provided to people. Complaints and outcomes from safeguarding investigations had not been used to improve the service overall.

We found multiple and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found that there was not enough improvement to take the provider out of special measures and urgent action was taken.

The local authority made arrangements for all people living at the service to move to alternative services by 24 March 2016.

You can see what action we have told the provider to take at the back of the full version of this report.

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.

The environment was not clean or safe. Improvements were needed to ensure any risks to people's safety and welfare were identified and acted on.

There were not sufficient numbers of staff to meet people's needs safely. The service did not follow safe recruitment procedures.

Medicines were not being managed safely. People were not provided with their medicines as prescribed which may put people's health and welfare at risk.

Is the service effective?

Inadequate

The service was not effective

Staff were not effectively trained to meet the range of people's needs who used the service. This impacted on the quality of care they received.

The Mental Capacity Act and Deprivation of Liberty Safeguards were not effectively understood by the providers or staff. Improvements were needed in how the service ensured people's legal rights were protected.

People's nutritional needs were not been effectively monitored, and shortfalls acted on, to ensure all people were given enough to eat.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff interacted with people in a caring manner.

People's privacy and dignity was not always promoted and respected.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not staff with enough information to ensure people received safe care that was tailored to their needs.

The service did not use the information they received through complaints and feedback to mitigate risk and drive improvement.

Is the service well-led?

Inadequate

The service was not well-led.

Improvements were needed to develop a positive inclusive atmosphere where people using and working for the service are heard and used to drive improvement.

The provider continued to fail in their duty to have systems in place to monitor the quality of the service or to protect people's safety and welfare.

The provider failed to display or project good visible leadership.

Fairlawns Care Home

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 unannounced inspection took place over two days, 10 and 11 March 2016. The inspection team consisted of thee inspectors on the first day and two inspectors on the second day. We wanted to check that the action the provider told us they had taken to improve the service following our previous inspection on 30 August 2015, had been made and sustained.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan. We reviewed all other information sent to us from other stakeholders such as commissioners, environmental health and feedback received through the CQC website.

We spoke with seven people who used the service and two people's relatives. We spoke with five members of staff, including care staff, senior care staff, the manager and the provider's representative. We also spoke with a health professional and two social care professionals. We have informed the fire safety officer and the environmental health officer of our concerns.

We looked at records relating to all of the people who used the service regarding their care and management of medicines. We also looked at seven staff training and recruitment records, and systems for monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection of 20 August 2015 found that improvements were needed to keep people safe in the following areas: management of people's medicines, maintaining safe staffing levels, recruitment of staff, identifying risks associated with the premises and people's individual needs, maintenance of the service and ensuring people had equipment in place to support their independence and safety. This inspection identified that little change had been made, and where the provider said, in their action plan, they had made improvements, they had not been maintained these improvements.

The provider failed to ensure that there were sufficient numbers of suitably qualified staff to keep people safe and to meet their needs. One person told us, "There is not enough staff. There is only two on at a time which is not enough … staff cannot always come straight away which is why I had an accident just now and wet my clothes. This is because they are busy with someone else."

Records showed that there were always two care staff on duty during a 24 hour period. There was also a part time cook, but no domestic staff. Care staff were expected to do all the domestic chores in the service, including the laundry. They also prepared, cooked and served meals when there was no cook on duty. These duties often left only one member of staff available to provide care. The needs of people meant that this was not enough staff to keep people safe. There were three people who needed support from two staff when moving, and another person whose behaviour could put other people at risk. When the staff were out of the communal area attending domestic tasks or supporting people who chose to stay in their bedroom, others using the communal areas were left unattended and could be at risk.

Added pressure was also placed on staff in the absence of management / office staff as they had to open and close the front door for people/visitors and answer the telephone. A health professional was not been able to gain access to the service. On arriving they found a visitor who had already been waiting 10 minutes to gain access. The health professional waited a further 10 minutes and after unsuccessful telephone calls to the service, which they could hear ringing, they left. This resulted in a person not receiving their treatment that day.

No systems were in place to regularly assess that the staffing levels were based on the needs of the people. When we asked the manager how they decided the staffing levels they told us, "I inherited two staff on each shift and that's what it is." They told us that there were enough staff on duty. This contradicted what staff told us and our own observations. One staff member spoke about how difficult it was meeting people's needs, especially at weekends, when there was no cook or manager on duty. We observed that the manager responded to call bells several times during our visit. They did not work weekends so we were concerned that with no additional support people's needs would not be met in a timely or safe way.

The manager told us only senior staff administered medicines. There were only three senior staff in post at the time of our inspection. We were advised that when a senior was not on shift one would come in specifically just to administer medication. The manager confirmed that the staffing rotas were not accurate as they did not show these additional hours.

We returned to the service the following day (11 March 2016) because we received information of concern. On arrival we found there were significant gaps in the staff rota which had not been filled. In addition there had been no senior member of staff on duty during the morning and therefore no medication had been administered. We were so concerned that we contacted the local authority who provided experienced staff to support the existing staff.

This was continued breach of regulation 18 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service's recruitment procedures were not robust enough to ensure all staff were of good character, and had the skills and experience for the post they were being recruited to. The manager's understanding of their duties in regards to safe recruitment of staff was inadequate and placed people at risk.

Records and discussions with staff showed an inconsistent approach to the recruitment of staff which put people at potential risk. For example, one staff member told us they were interviewed, but had not been asked to complete an application form. They started employment prior to the required checks being carried out to ensure they were allowed to work with vulnerable people. This was confirmed by their recruitment records and by the manager. Where information had been received, which could question another staff member's suitability to the post they held, there was no record to show that the information had been considered prior to employing that member of staff.

When we arrived on the 11 March 2016, the care staff member on duty said they had previously been "Dismissed" in Autumn 2015 by the service for not having completed the required training. However, they had received a telephone call from the manager that day asking them to work the shift. They said they were unsure of their employment status and that the manager said they would discuss it with them after the weekend, when the manager returned. No new recruitment checks had been carried out to ensure they were still suitable to undertake their role.

Another member of staff had been given the position of senior carer. Their application showed that they had not provided a full employed history, so any gaps in employment, and the reason why had not been explored. Especially as the information supplied showed they had no previous experience in social care, or 'transferable skills' that would make them suitable for the post they were given.

Improvements were required to ensure references were obtain to confirm prospective staff members were of good character and had the personal values, skills and experiences they were looking for. For example, one staff member's file held two character references and none from previous employers, including a social care organisation identified in the application form. When this was pointed out to the manager they said they had not noticed.

This was a continued breach of regulation 19 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we found multiple shortfalls in the way the medicines were recorded, ordered, received, stored, administered and disposed of. This included where a person's course of antibiotics had not been recorded on their medicines administration charts (MAR) as received, or given. The manager confirmed that they were aware that they had not been recorded as being administered on the MAR and would ensure it was done. When we returned the next day this had not been done. In addition the person had not been given their antibiotics which had disrupted their course of treatment. The person put their discomfort down to not receiving their medicines.

Records identified where people had not been given their pain and sleeping medicines because they had not been re-ordered in time. Entries in the staff handover book included, that a person, 'Is in a lot of pain, still no pain killers please can this be sorted in the morning?'

The manager confirmed and we saw that senior staff had 'potted up' people's medication which was then carried around the service on a tray. Staff told us this practice was also being used by some senior staff on night duty who would dispense people's medicines into the pots, ready for day staff to give out. This was unsafe practice, as there was a potential risk of the pots being knocked over, medicines being lost, or given to the wrong person. Comments made in the staff's handover book, and records, showed that staff were also not following safe practice of checking the medicines to be given, against the person's MAR to ensure it was correct, before giving them to the person. This put people at further risk of not receiving their medicines as prescribed. In another example we saw that a relative was bringing in food supplements for another person. They told us that the person had been prescribed them prior to moving in and had nearly run out. There was no information in the person's care records about the person taking food supplements.

There were discrepancies for controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) including the inappropriate completion of records by staff. We were unable to tally the amount of a person's controlled medicines against the controlled drug record book. The manager was unable to explain the discrepancy. Because staff had not identified the shortfall no action had been taken. Where there are discrepancies relating to controlled drugs these are required to be formally reported and investigated. There were also no restrictions on who could access the area where the controlled drugs were stored.

The temperature of the room and refrigerator were not being checked to ensure medicines were stored at the correct temperatures. The thermometer recorded the room temperature at 27° Celsius which was higher than the recommended temperature of 25°Celsius. Storing medication at high temperatures can stop them working as they should. We found discarded medicines in the waste bin. The manager confirmed that they should not have been in there, as their policy was to record when a person had not taken their medicine and return it to the dispensing pharmacy. The shortfalls we found in the recording of people's medicines in and out of the service meant there was no clear audit trail to be able to check that people were receiving their medicines as prescribed.

On the 11 March 2016 two people contacted the Commission concerned that due to there being no manager or trained staff on duty, people had not been given their morning medicines. They told us that the manager was aware, but no action had been taken. We alerted the local authority safeguarding team and returned to the service. We found no one had been given their morning medicines. This included medicines important to support people's health including heart conditions, diabetes, antidepressants, pain management and those prescribed to prevent blood clots forming. There were two staff on duty but neither had been trained to give medicines. Records showed that a member of staff had come in and given the lunch time medicines and left. No action had been taken by that member of staff to see if any of the morning medicines could be given at lunch time. The local authority were so concerned about people's welfare, they arranged for another care provider to come in and give people their medicines to mitigate any further risk. This arrangement continued until everyone was moved from the service on 24 March 2016.

Risks associated with the care people received and the environment they lived in were not being managed effectively. This impacted on people's safety and well-being.

We received mixed feedback on the cleanliness of the service. One relative said staff kept the person's bedroom, "Lovely and clean." Where another relative told us that they often found shortfalls in the standard

of hygiene. The comments they made reflected our own observations, where a person's toilet and floor were seen to be dirty and systems in place for infection control were not in place.

Some people had pets at the service. Whilst this was positive for individuals, no associated risks had been assessed. Cleaning schedules were not in place to ensure that pet faeces in the garden was regularly cleared and we noted that carpets throughout the ground floor had a build-up of pet hair. There was no tumble dryer; staff were reliant on line drying or hanging items around the service. Wet/damp towels were being removed from arm chairs soon after we arrived. All three washing machines were out of action, which had resulted in a build-up of dirty linen. Feedback from staff and relatives identified that this was a frequent occurrence. In the laundry the floor and work surfaces had a pile of dirty linen waiting to be washed. We saw a member of staff, wearing gloves, carrying soiled linen. They told us they used to use dispersal red bags, which allowed them to reduce the risk of cross contamination. They did this by placing linen straight into the bag then into the washing machine without further contact. However they told us they no longer had these.

The provider's representative (a Director) confirmed that they no longer used the red bags, as they blamed them for blocking the washing machines and causing them to break down. However, no action had been taken to find an alternative system. Given the concerns we had about infection control, staff practice of using the kitchen as a 'cut through' to other areas of the service also had risks which had not been assessed.

Information held in people's care records did not cover all risks associated with their individual care, health and support needs. This included risks associated with people's skin becoming sore and/or breaking down, the use of a wheelchair and accessing the garden. Risks associated with people's individual physical and mental health needs had not been identified and acted on. For example, there was no risk assessment to support staff in dealing effectively with people's behaviours which staff could find challenging. A member of staff said that they were not supported to deal with people when they became distressed, they just tried their best, "We are expected to deal with it and be shouted at."

Even though some risks had been identified staff still failed to take action to minimise it. For example, where a record stated 'risk of getting stuck with hoist,' the method put in place was to 'keep battery charged.' However, records provided information where this was not happening and had impacted on a person's comfort and safety, 'hoist playing up due to low battery, can we put it on charge every time we use it to save the person being up in the air uncomfortable?' Another entry written three days later showed it was still happening and the person was complaining that they were in discomfort.

On 10 March 2016, a person approached us when we arrived looking anxious and said the lift, which had been serviced the previous day, had broken down. They told us that they had been, "Stuck in the lift," in the dark for at least 20 minutes. Staff said that the person could have been released straight away if staff had known what to do. Instead they had to wait until the manager could be contacted /arrived, which resulted in the delay.

Despite assurances that the lift would be fixed, when we arrived the following day it was still out of action. The same person asked us if the lift was working. There were no signs informing people it was out of use. Although the downstairs lift door had been locked, on the first floor we were able to get into the lift. This meant if the person had tried to use the lift, they would have been trapped again as they would have been unable to get out at ground level until staff unlocked the door. We brought this to the attention of staff who then locked both access points.

Health and safety checks had not been carried out to ensure people were provided with a safe environment.

This included fire panel and emergency lighting testing, legionella water tests, water temperature checks and Control of Substances Hazardous to Health (COSHH) assessments for chemicals used in the service. The electrical installation certificate was out date, when we alerted the provider to this, they arranged for an electrician to carry out the checks on the 12 March 2016. The provider's representative gave us a copy of the report which showed that the overall rating for the condition of the installation was 'unsatisfactory'. The report identified six items which needed 'urgent remedial action required'. We were given no clear assurance as to when the work would be carried out.

Fire risk assessments were out of date and did not take into account all identified risks to people. For example, use of door wedges to hold open people's bedroom doors had not been assessed. Therefore, if a fire occurred, the potential risk to the person was increased, because the doors could not automatically close to provide a barrier. The manager told us that there had been one fire drill since they had started working at the service in August 2015, but could not remember when it was and could not find any record. The manager confirmed not all staff had completed fire safety training.

Action was not being taken in a timely manner to ensure people were provided with equipment which supported their safety and wellbeing. We observed two staff members supporting a person to transfer using equipment designed to support people who could weight bare. The person told us they were, "Not comfortable at all," because they could only partially weight bare, "The straps hurt me on my upper arm because my arms are taking all of my weight. I do not feel safe in the hoist." They said that they had been assessed for a different type of sling which would not hurt them. However this had been a couple of months ago. The manager confirmed that a new hoist had not been purchased as they were awaiting agreement from a Director to purchase the new slings.

Our inspection of 20 August 2015, identified where call bell extension leads had not been fitted to ensure people could have adequate means to summon assistance. A person told us during this inspection that they had been unable to use a call bell until a member of staff took the initiative and wired in an extension lead. Staff told us that they had found the person trying to lean across their bed using a stick they had been given to activate their call bell. The manager told us that they were aware of the action taken, and referred to the member of staff as a maintenance person who was competent to carry out the work. However, they were unable to find records to confirm this position, or that they were qualified / deemed competent to undertake tasks involving electricity. We were also concerned that a potentially untrained member of care staff had been dealing with electric wiring, which could have put them and the people who used the service at risk.

These were continued breaches of regulation 12 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Our previous inspection of 20 August 2015 found that improvements were needed in the training of staff, supporting people with their nutrition, and ensuring people's human rights were not encroached. This inspection identified that little changes had been made, and where the provider wrote and said they had made improvements, they had not been maintained.

Not all staff had received training to meet the needs of the people who lived in the service. Two staff employed in November 2015 had not received any training since starting. Both staff member's files held certificates of training completed in their previous place of work, but there had been no checks on their current competence to perform their role at Fairlawns. The manager told us they knew that this was the case but could not explain why they had not had their training needs assessed. People living in the service were all frail and vulnerable. They included those living with dementia, diabetes, stroke, depression, and age related conditions which affected people's mobility and continence. There was no training plan in place linked to the range and needs of people using the service. The manager and director were unable to demonstrate how staff were being trained to understand and meet people's needs.

One of these two staff members had been appointed as a senior care staff member which was a position they had not held before. The manager confirmed they had received no additional training for this role. This included no medicines administration training, despite this being one of their key responsibilities. This meant that the people did not receive effective care from staff that were knowledgeable about their responsibilities or had the skills they needed to carry out their role.

The provider had not ensured that the person managing the service had the relevant skills. For example the manager acknowledged that they needed training in medicines management as their own knowledge was not up to date and they did not have the skills or ability to oversee staff practice.

This was a continued breach of regulation 18 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to ensure that the manager and staff understood their responsibilities with regards to Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 within the care home setting.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

There were people living in the service whom we were told did not have capacity or had fluctuating capacity. One person's relative told us they had moved to the service because they were living with dementia and lacked capacity to make decisions about how to keep safe.

The provider had not properly trained and prepared their staff in understanding the requirements of the MCA in general, and (where relevant) the specific requirements of the DoLS. The manager and a director did not demonstrate an understanding of MCA or DoLS and could not demonstrate they had undertaken training relevant for the service they were providing. Records were not in place to show any other staff had undertaken this training.

The manager said no one apart from the staff had the code to open the door of the service. The manager was unable to demonstrate that they had considered these arrangements against the DoLS and explored with other professionals whether or not they were appropriate for each person and their liberty was not being restricted unnecessarily.

This was a continued breach of regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not being effectively identified, monitored and managed, which put people at risk of being malnourished. The service did not use a recognised tool to support them in identifying significant weight loss and then take appropriate action. This included putting people on a fortified diet to increase calorie intake and / or referring to health professions such as a dietician, GP or speech and language therapist to identify any health concerns.

Staff told us people's weight was recorded monthly and no one had been identified as requiring an enriched or specialist diet such as extra nutritious snacks between meals to support their health. However, records showed where people had been losing weight. For example one person had lost 4.2 kilos between December to January. No year had been entered on the records, but staff confirmed that they were for 2015/16. No further weight had been recorded for February 2016. Records did not show and staff could not tell us what action had been taken in relation to the person's recent significant weight loss. Care records provided no guidance to support the person apart from one line comments such as 'person does not eat much try to get [person] to eat more'.

Another person's records showed that they had lost 2.4 kilos between December and February (again staff confirmed 2015/16). Records showed that they were eating very little at times and no action had been taken when they had refused meals. The only mid-morning and afternoon snack recorded was a biscuit. The manager and director were unable to explain what action should be taken to support people at risk of malnutrition.

This was a continued breach of regulation 14 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Our previous inspection of 20 August 2015 found that improvements were needed to ensure that all staff attended to people's needs when asked in a respectful and dignified way, and ensured people's privacy by keeping their personal and private records secure.

This inspection identified some improvements, but no action had been taken to ensure people's private information was stored securely. We found care records, which contained personal and private details about people were still stored on the desk in an unlocked, unoccupied staff room. The door could not be secured, as no lock had been fitted. We saw a visitor pop their head into the staff room; they told us that they were looking for a member of staff. This showed that the records were open to scrutiny by people other than those who were authorised to have access.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Practices within the service did not always ensure people felt valued and respected. For example one person's choice about where and how they ate their meals had not been explored; this resulted in the person becoming disengaged and losing weight. The impact on the person had not been recognised.

With no drying facilities in the service, visitors told us they often arrived to the sight of damp washing hanging along the hand rails in the corridors, as staff tried to get them dry. One visitor told us it included people's clothing, "I wouldn't like people seeing my underwear on display, not very dignified."

These are continued breaches of Regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Despite the provider's shortfalls in ensuring best practice within the service, we saw that in most cases staff wanted to provide good care and were intuitively kind. One person told us, "The carers are very good caring people." A relative described staff as, "Really, really nice, very helpful." Relatives told us that staff were approachable and made them feel welcome during their visits.

We saw that staff still did not have the time to sit and have meaningful talks with people who remained in their bedrooms. One person told us that staff did not have time to, "Chat, too much to do." In the dining room, whilst staff carried out tasks, they instigated conversations with the people sitting having breakfast. When a person became distressed, staff straight away sat and provided reassurance in a supportive way.

We saw friendships had developed between some of the people using the service. Three people sat in the dining room, chatting about their life and reminiscing about hobbies. We could hear them laughing as they joined in gentle banter with each other. One person told us that they had been pleased as they had been able to bring their pet within them during their stay. Another person also had their pet living with them, which we saw meant a great deal. For both people we saw that it enhanced their wellbeing.

Inadequate

Is the service responsive?

Our findings

Our previous inspection of 20 August 2015 found that improvements were needed to ensure that people were involved in the planning of their care needs, in a way that would lead to personalised care that was responsive to their needs. The provider wrote to us and told us that they had reviewed people's care plans to ensure they were 'fit for purpose'. They had carried out a complete assessment of all aspects of people's personal care, health needs and activities of daily living. People and their relatives had been 'empowered and encouraged to contribute,' and care records were reviewed and updated on a regular basis to ensure they met people's 'specific needs'.

Despite these assurances, at this inspection, we found care plans still did not provide staff with sufficient guidance to support people with their individual needs. The information given was more a summary of some of the person's needs. There was limited information to support staff in getting to know about the person and how that person wanted to be supported with their care in a way that met their individual preferences, aspirations, and social interests. For example, where a person's care plan stated, 'anxiety easily triggered, disorientated at times,' there was no further information on potential anxiety triggers, or situations that could lead to them becoming disorientated; to reduce the risk and offer appropriate support.

Staff were not using or referring to best practice guidance in supporting people living with dementia. This is especially important where people's mental frailty impacts on their ability to recall significant life events. Having this information would have supported staff in instigating meaningful conversations, and being aware of any events or actions that could trigger their anxiety.

Records held conflicting information which could put people at risk of not receiving care responsive to their needs. For example, there was conflicting information on the care plan for a person relating to their continence needs. It wasn't until we checked with the person we knew which of the records was correct.

Information given on people's medicines and medical history was very basic. One person's care plan only identified one of their medical health conditions. However, the list of 'medication' recorded on their care plan, identified that they had a range of physical and mental health needs. There was no information about how these needs were being met and monitored by staff. Without providing staff with information on people's health issues, what medicines they were taking and why, staff could not effectively support and be responsive to the person's needs. This included being aware of any side effects of medicines which could impact on a person's health, comfort and safety. Examples of these included, constipation linked to taking strong pain killers, or where a person was taking anti blood clotting medicines, if they fell, the higher potential risk of internal bleeding. None of these issues had been explored in the care records viewed.

The manager had introduced different daily activities including, bingo, music, puzzles and a visiting library service had been organised .Although this represented some improvements in people having access to mental and social stimulation, it was still very limited. One person told us, "It's boring, nothing to do." They told us they had bingo, "But I don't like bingo." Another person said they, "Sometimes have a film

afternoon." Another person mentioned the entertainers that had come in, "We want the couple that come in the other day, had a dance." Which they had enjoyed.

We spent time talking with a person who spent long periods of time in their bedroom, we saw that having company had a positive impact on their wellbeing. Discussions with staff and our own observations identified that the person was at risk of social isolation and becoming withdrawn. Care plans provided no information on how people were being supported to prevent this. There was a reliance on relatives (or other outside influences) or people joining in with organised activity, rather than tailoring social interaction to meet the person's individual needs.

This was a continued breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 20114.

People told us if they had any concerns that they would raise it with the manager. One person told us, "I think the manager would sort things out if I was not happy." A relative provided examples of where they had raised concerns with the manager, who would say, "Leave it with me." They told us that the manager had acted on their concerns but improvements were short lived, which resulted in the same concerns being raised again. They told us although the manager acted on the concerns; no action was taken to prevent it reoccurring again.

Records showed that complaints were a set agenda item during management meetings. It enabled the manager to update the provider on any complaint and action taken. The manager told us, which was confirmed by staff, that they were putting forward a request to the provider for seven hours a week domestic cover as a result of concerns about the cleanliness of the service.

Inadequate

Is the service well-led?

Our findings

Our previous inspection of 20 August 2015 found that improvements were needed. We found that the provider did not understand the principles of good quality assurance and oversight to drive improvement within the service. This inspection identified sufficient action had not been taken and the quality of the service had deteriorated further placing people at risk. There were widespread and significant shortfalls.

Support and resources to run the service well were not always readily available. In addition, care and support was intuitive rather than based on good practice or management support. One member of staff remarked, "It takes a lot of nagging to get things we need," that it had taken five months to replace a washing machine and that they had, "Struggled to get the clothes clean." Staff provided examples of where they had raised concerns and no action had been taken by the provider or management to address them. This included telling the management the staffing levels at weekends were not sufficient to meet people's needs and asking for a bigger food budget. One staff member told us, "We are always asking for more money for food…by Saturday / Sunday we are scrimping together for food as we run out of money." The weekend following our inspection, we were alerted by social care professionals that there had been very little food in the service. This had resulted in them buying food and taking it into the service to ensure people had enough to eat.

The provider did not promote a positive culture where good practice was encouraged to improve quality and effective action was taken to address shortfalls. Staff's concerns were not always listened to or acted on, so opportunities to improve in a timely manner were missed. Another example where the provider and management were failing to listen and act on feedback from staff to drive improvement were the entries in the staff communication book. There were several entries which raised concerns that people were running out of their medicines and where staff were not following safe practice. The shortfalls we identified during the inspection confirmed that these concerns had not been acted on.

The leadership of the service was weak and was unable to demonstrate knowledge of best practice and skills to run the service. For example, the manager oversaw and was complicit in poor practice around medication management. A director who visited the service regularly did not have the knowledge to be able to check that the service being provided was of a good quality.

During our inspection neither the manager nor a director showed a good knowledge of how to monitor the quality of the service people received or how to audit it. They were unable to demonstrate how the shortfalls we had identified would be robustly addressed in a proactive way.

The manager said that they monitored the service on a day to day basis; they talked with people and watched staff working. They acknowledged that they did not have any formal quality audit system in place. We asked to see the service's quality assurance policy but it could not be found. The manager showed us a quality assurance folder but told us they had not read it and was not aware of the audits they should have been carrying out as listed in the folder. A director told us they were responsible for line managing the

manager but they had not checked that this work was being completed. This raised concerns over the level of support the manager was receiving from the provider to ensure they were able to effectively carry out their responsibilities.

We were provided with a copy of a quality visit; it was labelled 'management meetings' dated 27 November 2015. Two directors and the manager were present at the meeting and the report listed many actions that had been identified. It showed who had been given responsibility for different parts of the service to monitor and drive improvement. For example, the manager was to ensure that the home was to be maintained in a clean condition at all times and that one of the directors, who visited the home at least weekly, would tour the building t to ensure cleanliness was maintained. This system was either not happening or ineffective given the poor cleanliness of the service. Staff had also highlighted this as a concern.

We also found other concerns around health and safety which had not been addressed. The Electrical installation safety certificate was out of date, door wedges were being used to hold open fire doors and relevant fire risk assessments were not being carried out. A relative contacted us following the inspection and confirmed that the door wedges had been removed, however they said that the 'reactive way' the provider dealt with it, had resulted in the person becoming , "Very distressed," as they were now unable to open their bedroom door independently. No consideration had been given to the use of fitting an automatic closure at that time, which would have prevented causing the person, living with dementia, this anxiety.

The provider had no system in place to ensure that there was adequate oversight of the quality of people's care. For example, we asked if the manager had carried out a falls analysis, so that they could look for reasons of people's falls and take action to avoid them happening. The manager told us they had not, because no one had fallen since they had become manager in August 2015. However, we saw records that showed people had fallen after this date, including one person had sustained a fracture because of a fall.

The provider and manager's failure to carry out quantity monitoring audits, such as care plan reviews, the administration and review of records of medicines, infection control, staff files and health and safety checks meant that they did not have an overview of how well they, the staff and the service overall was performing. They had not independently identified the breaches to regulations that we found during our inspection and had failed to take action to rectify them which put people using and working for the service at risk.

This was a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People were at risk from the unsafe administration of medicines.

The enforcement action we took:

We have taken urgent action as we believe a person will or may be exposed to the risk of harm if we do not do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued to fail in their duty to have systems in place to monitor the quality of the service or to protect people's safety and welfare.

The enforcement action we took:

The Registered Provider must not admit any service users to Fairlawns Residential Care Home without the prior written agreement of the Care Quality Commission.