Fairways Residential Home Limited

Fairways

Inspection report

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Tel: 01524855222

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Fairways is a residential care home. It is registered to provide care and accommodation for up to 24 older people some living with dementia. The home is based over three floors with a lift for access to all floors. There were 22 people residing at the home at the time of this inspection.

People's experience of using this service and what we found
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We were not assured the infection prevention and control practises in the home were satisfactory. Infection control practices and the management of infected clinical waste in relation to the pandemic and Covid-19 were not being followed in line with government guidance or the homes infection control policy. This exposed people to potential risks of avoidable harm.

Some accidents and incidents within the home which had resulted in harm had not been always been adequately managed or escalated in line with the local authority safeguarding procedures and the registration requirements to notify us. Failing to recognise or report serious incidents put people at risk of receiving unsafe care and treatment.

Risks in relation to the management and oversight of fire safety within the premises was not consistent.

Where specific equipment was in use the risks associated with their use was not always managed in line with current national health and safety guidance. This put people at risk of potential or avoidable harm.

Systems in place were not effective enough to support the safe management and administration of medicines. There were unsafe practises for the management and administration of as required (PRN) medicines This placed people at risk of harm from unsafe practices in relation to the management of medicines.

Processes and systems in place to oversee, assess and monitor the safety and quality of service provided were not effective. This meant that appropriate actions could not be taken to ensure the service consistently provided safe care and treatment.

Recruitment practices adopted by the home were not robust. New staff had not been thoroughly checked prior to employment commencing. This meant staff were not checked as being suitable before commencing work with vulnerable people.

People were not always supported to have maximum choice and control of their lives. Staff did not always

support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

We observed people were treated with kindness and compassion. Interactions by staff with people were seen to be in a respectful and caring manner. One person living at Fairways told us they were very happy and said of the management and staff, "I love all of them so much."
Relatives spoke very positively about the care provided. One family member told us, "I feel mum is safe here and also "It's homely and more like a family, there's a warmth to the place." Another relative said, "The home has been very good at communicating with us throughout Covid. The manager is always available to talk to."

Staff we spoke with all told us they loved working at Fairways. On staff member said, "The bosses are brilliant, everyone is so supportive. They [the management] are so approachable, there's nothing you feel you would not be able to say."

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

Rating at last inspection
The last rating for this service was good (published 08 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received about a specific incident resulting in an injury. A decision was made for us to inspect and examine those risks associated with the management of falls.

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

The provider took immediate actions to mitigate some of the risks we found in the practises of infection prevention and control and in making the environment safer. This minimised the potential of harm being caused.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to infection control, recruitment, safe use of equipment, reporting of

incidents, management of medicines, and in risk assessing and monitoring the service at this inspection. We have also identified a potential failure to inform CQC of notifiable incidents and this will be dealt with outside of this process.

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

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our well-led findings below.

Fairways

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify any good practice we can share with other services.

Inspection team
The inspection was conducted by three inspectors. Two visited the home and the third made telephone calls to relatives and staff.

Service and service type
Fairways is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
Two people who lived at the home talked about their experiences of the care provided. We spoke with the senior carer, the registered manager, and one of the company directors of the registered provider and who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at the maintenance and cleanliness of the premises and reviewed a range of records. These included five people's care records, medication records, accident and incident records and four staff personnel files. We also looked at a variety of records relating to the management of the service, including some policies and procedures.

After the inspection –
We spoke with two relatives and two members of staff by telephone. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were put at risk of avoidable harm.

Preventing and controlling infection

- People were not being protected from the risks of Covid-19 and other infectious disease, because the provider did not have effective control measures in place to mitigate the risks.
- Relatives said they felt people were safe at Fairways. One relative told us, "I've not for one moment worried about my relative at Fairways during Covid." Another relative said, "I feel my relative is safe and well cared for."
- Staff were not complying with the use of Personal Protective Equipment (PPE) in line with national guidance. Staff did not always change items of PPE between completing different tasks. Points of access to PPE throughout the home were not sufficient.
- Some parts of the environment were unhygienic and needed deep cleaning or repair. Pieces of equipment or fittings such as radiators and a bath hoist were seen to be damaged, dirty or dusty. Contaminated clinical waste was not being managed safely. We made a referral to the local infection prevention control team.

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

- Risks to people's health and safety had not always been assessed or managed effectively. During the visit we identified some concerns relating to fire safety. We requested a visit to the home by a fire officer from Lancashire Fire and Rescue Service fire safety team. The officers identified some failings and discussed some minor issues with the provider and gave advice including the completion of an up to date fire risk assessment of the premises.
- Known risks associated with the use of specific equipment had not always been mitigated. We saw a bedrail in use that had no bed rail bumpers in place as per national guidance on the safe use of bedrails. The registered manager immediately addressed this.
- Where restrictive practises were in place such as bedrails records did not always provide clear evidence that decisions had been made in people's best interests. This placed people at the risk of being unlawfully restrained.
- Where weight loss had been identified the processes in place were not effective in managing the risks and could not ensure people received the right care and treatment in a timely way.
- Where accidents and incidents had occurred resulting in serious injury, they had not always been reported to the appropriate authority including us. During the inspection we asked the registered manager to report three incidents to the local authority safeguarding board. Failure to recognise or report serious incidents put people at risk of receiving unsafe care and treatment.

Using medicines safely

● Medicines were not always stored and managed safely. Processes to manage medicines with a short shelf life were not always used increasing the risk of medicines expiring past their best use. Temperature records for which medicines were stored were not effectively managed in order to prevent medicines becoming damaged and being made ineffective.
● People were exposed to risk of harm, as systems were either not in place or effective enough to support the safe management of medicines. We found a discrepancy in the records of stock numbers of an as required (PRN) medicine. Staff had used an alternative stock of the PRN medicine, making it difficult to balance stocks of medicines correctly.
● There were no written protocols for staff to follow when using PRN medicines. People were at risk of their PRN medicines not being used appropriately or ensuring people received the right level of treatment.

We found no evidence that people had been harmed. However, the above findings placed people at risk of potential harm. This was because risks to people's health and safety were not being managed effectively, medicines management was unsafe and infectious disease transmission was increased at a time when lives were at put risk during a national pandemic. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough numbers of staff through the day to ensure people received the necessary level of support in a timely manner. However, there was not enough staff to fulfil the home's fire evacuation procedure for night time. The provider took immediate action and increased the number of staff working during the night.
● Staff said they thought there were enough staff. On staff member said, "There are enough staff. We have a hostess who helps with meals. This frees us up to give personal care."
● The recruitment process used was not robust when checking if people were suitable to work with vulnerable people. Some people had commenced work without all the necessary checks in place.
● We looked at the personnel records of four staff members and found all of the information required to safely recruit fit and proper people had not been completed. This placed people at risk of being supported by staff who had not been deemed fit to work with vulnerable adults.

We found no evidence that people had been harmed. However, recruitment practices were not robust enough to show staff had been adequately checked before they commenced employment. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems used to report incidents and accidents in the home had recently been improved to ensure that all events were reviewed by the registered manager. However, we saw that this process was not consistently followed for all events meaning that learning lessons could not be always be properly implemented. We have addressed this in the well-led section of this report.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Oversight in the home did not assure the delivery of safe high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The provider's systems and processes in place for the oversight, quality monitoring and safety of the service were not effective in detecting the concerns we found during the inspection.
- The oversight of the requirements in managing risks of fire were not current and therefore put people at risk of harm.
- The oversight of Infection control practices in relation to the pandemic and Covid-19 were not being followed in line with government guidance and the homes policies and procedures.
- The quality monitoring systems were not effective in ensuring a robust recruitment process was in place. The checks of suitability to ensure staff were fit and proper to support vulnerable people had not been sufficiently monitored.
- The home's procedure in place for weight loss management was generic and not person-centred. This meant for some people, already at a low body weight the procedure was not effective..

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

- The provider did not have robust systems in place to ensure compliance with regulations and to assess and monitor the quality of service provided.
- The provider had not always referred serious injuries and significant incidents under the local authority safeguarding procedures. The managerial oversight of the incident and accident records to ensure appropriate action had been taken and reporting processes had been followed were not effective.
- There was no evidence available to show how the registered provider, manager and staff team had learned lessons when things went wrong in order to improve the standards of care within the home and to protect those who lived at Fairways.

The above findings demonstrate that the registered provider had failed to arrange robust oversight of the service in order to assess, monitor and improve the quality, safety and welfare of service users, who were put at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Care plans and risk assessments had been regularly updated and were reflective of people's current needs.
● Staff spoke very positively about working at Fairways, the support provided by the provider and registered manager and the level of involvement they had in the delivery of the service. One staff member said, "I absolutely love it, I'm really happy working here. I feel very supported by the managers" and "I'm always speaking at meetings and feel listened to." Another staff member told us, "We can air any issues, managers listen to different approaches. We all work together to see how things work."
● Relatives were very happy with the service provided. One relative said, "There is really good communication with me and any concerns we have are shared. The staff actually care." Another relative told us, "The home has been very good at communicating with us throughout Covid. The manager is available to talk to at any time."

Working in partnership with others
● The nominated individual/provider, manager and staff team had established good working relationships with a variety of professionals within the local community. Following the inspection, the provider took immediate action to start addressing shortfalls we had identified. The provider has shown a willingness to work with other social and health care organisations in order to improve people's experiences and the quality of service provided

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a failure to implement robust recruitment practices to ensure staff had been adequately checked before they commenced employment.

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 There was a failure to ensure care and treatment was consistently provided in a safe way because risks had not always been properly assessed and actions had not always been taken to mitigate identified risks. People were put at risk of harm from poor practices in relation to the management of medicines. There was a failure to ensure infection control practices were followed safely and people were not protected from the transmission of Covid-19 and other infectious diseases. There was a failure to recognise and report serious incidents putting people at risk of receiving unsafe care and treatment.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure the quality and safety of the service provided. The systems and process in place for the oversight, quality monitoring and safety of the service were not effective. Some processes, policies and procedures were not always followed correctly this put people at risk of not receiving safe care and treatment. The oversight of risk management was not robust

this put people at risk of potential harm.

The enforcement action we took:

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