Amira Residential Homes Limited

Fairhaven

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	
Is the service responsive?	
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 October 2014. After that inspection we received concerns in relation to staffing levels, staff recruitment processes, staff knowledge and skills, administration of medicines and the quality of the food people received, As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

The inspection took place on 01 December 2014 and was unannounced. Fairhaven provides accommodation and personal care for up to 21 older people. It does not provide nursing care. At the time of our inspection there were 17 people living at the home.

The home is required to have a registered manager. 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'.

Summary of findings

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 provider is also the registered manager.

There was insufficient staff at all times to provide the level of care that people needed. Not all staff were aware of their responsibility to safeguard people or could identify the types of abuse people may suffer. Not all identified incidents of abuse had been reported to the appropriate safeguarding authority or the CQC.

Recruitment processes were not robust and proper checks had not been completed before staff started work at the home.

People did not receive their medicines as they had been prescribed. Medicine administration records had not been completed correctly and stocks of medicines held did not always agree with the recorded amounts.

The requirements of the Mental Capacity Act 2005 had not always been followed in relation to obtaining consent to care for people who were not able to make decisions for themselves.

Staff training was ineffective. Staff demonstrated poor skills when assisting people to move about the home. Staff were not always supported in the roles and responsibilities.

People enjoyed the food they received and there was plenty of it. However, there was no record that appropriate healthcare professionals were consulted about people's dietary requirements.

Records and data management systems were not robust. Records were not completed by the staff who had delivered the care.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in respect of staffing, staff recruitment, support for staff, the management of medicines, safeguarding, the provision of safe care, consent and record keeping. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

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There were insufficient staff to provide the appropriate level of care to people at all times.

Not all staff were aware of their responsibilities in respect of safeguarding.

People medicines were not managed effectively.

Inadequate

Is the service effective?
The service was not effective.

Staff were poorly trained.

Healthcare professionals had not been consulted about people's dietary requirements.

Requires improvement

Is the service caring?
We did not look at this question.

Is the service responsive?
We did not look at this question.

Is the service well-led?
The service was not well led.

The acting manager was not supported by the registered manager.

Staff who delivered care did not complete the appropriate records. This was done by senior staff.

Requires improvement

Fairhaven

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 was a focused inspection planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 following the receipt of information of concern about the service.

The inspection took place on 01 December 2014 and was unannounced. The inspection team was formed of three inspectors.

Before the inspection we reviewed the information we held about the service. We looked at the reports of previous inspections and the notifications that the provider had sent to us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with four people who lived at the home and the relative of another person. We spoke with the registered manager, who is also the provider, the acting manager, a senior care worker and two care staff.

We looked at the care records of two people who lived at the home. We also reviewed the recruitment files of four staff members. We looked at the management of medicines and checked the medicines administration records (MAR) for 10 people. We observed the staff interaction with the people who lived at the home. We also spoke with two social workers from the local authority who were supporting the service.

Inadequate

Is the service safe?

Our findings

People told us that they did not think that there was enough staff working at the home. One person said, "There are never enough staff. They are mostly very particular, but I think in the evening they could do with one more. When I call, at night I have to wait a while until they can get to me." Another person told us, "I have to wait for up to half an hour when I use the bell. It all depends how busy they are." They went on to tell us that they were supposed to have two care workers to support them to shower every day but they only ever had one. They told us that when they asked the one care worker where the other one was they responded, "I don't know."

The senior care worker we spoke with told us that there would normally be four staff to provide care and support to the 17 people who lived at the home during the day. However one person had called in sick on the day of our inspection and the service had been unable to get an agency worker at short notice. There was, therefore, only three care staff available. The acting manager told us that, since their arrival in October 2014, the level of staffing had not been four care workers. However, staff rotas we saw showed that on numerous occasions four care workers had been working. The registered manager and the acting manager appeared on the rotas as providing care and support for people. The registered manager, however, spent their time in the kitchen cooking the breakfast and lunchtime meals. The acting manager told us that the staffing levels had not been calculated to reflect the dependency levels of the people who lived at the home.

Records showed that during the weekend of 15 and 16 November 2014 there had been only three care workers, one of whom was required to cook meals and do the cleaning. Neither the registered manager, who cooks the meals on week days, or the cleaner normally worked at weekends. This left two care workers to provide care and support to people, four of whom required two care workers to assist with their personal care or support them to move around the home.

Records also showed that on 23 November 2014 there had been only two care workers available, one of whom was required to cook the meals and administer people's medicines. Only one care worker was therefore available to support people when the second care worker was otherwise engaged. We were told that one person had fallen and sustained a minor injury that day.

There was some confusion with the management as to the level of staffing at the home. There was, however, evidence to show that at times there was insufficient staff to care for people safely. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information that the recruitment practices at the home were poor. The recruitment files we looked at showed that the recruitment procedures followed were not robust. We found that essential checks had not been carried out before candidates had started work at the home.

We saw that one person had started work three weeks before the necessary checks had been completed. This person had gaps in their employment history for which the registered manager had failed to obtain a satisfactory explanation. The criminal records check, received three weeks after the member of staff had started work at the home, showed that they had served a custodial sentence. The member of staff had been issued with a contract of employment a copy of which showed that the registered manager was aware that the criminal records check had not been completed. When the necessary check had been completed on 4 July 2014 the registered manager failed to complete an assessment of the risks the staff member posed to people who lived at the home and other staff members. The acting manager completed a risk assessment on 27 November 2014 and the staff member was subsequently dismissed.

We saw that one very recently recruited member of staff had failed to provide any references. They had been living and working abroad. Although they had provided information about their previous employment no attempt had been made to verify this. This showed that the recruitment process remained unsatisfactory. They told us that they had received confirmation that their criminal records checks had been completed on 29 November 2014. They had started work at the home the previous week.

Inadequate

Is the service safe?

This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information that medicines administration procedures at the home were poor. People told us that they did not receive their medicines at any set time. One person told us, "It all depends when the nurse comes and gives them to me." They said they had their medicine, "…mainly in the morning, sometimes later or sometimes the night carers come and give me my medication." When we checked people's medicines administration records we found that people's medicines were not managed appropriately and people were not given their medicines as they had been prescribed.

When we checked people's medicines we found that one person had been prescribed a seven day course of antibiotics which they had started on 20 November 2014. However, the medicines administration record (MAR) had no entries to show that this medicine had been administered after 21 November 2014. When we checked the stock of this medicine against the MAR, we found seven tablets remaining instead of the 17. This course of medication had not been administered in accordance with the prescription. The course should have been completed on 27 November 2014.

We observed that two people who should have been given medicines either before food or with their food, did not receive these until some considerable time after they had eaten their breakfast. One person was given the medicine that they should have taken before their breakfast at 10.55a.m. The other person who was required to take their medicine with their food was given it and hour and a half after they had eaten their breakfast. These medicines had not, therefore, been administered in the way they had been prescribed.

We noted that there were staff members who were authorised to administer medicines. We checked 10 MAR's and found that only these seven staff had signed to administer medicines. This demonstrated that medicines had only been administered by staff trained to do so. However, one care worker with told us that the registered manager gave them medicine to put into one person's food as they would not take it otherwise. The acting manager confirmed that they had seen this happen. However, the care records for the person did not contain any mental capacity assessment or authorisation for the covert administration of medicines.

The acting manager told us that since their arrival at the home in October 2014, the GP had undertaken a medicines review for each person who lived at the home. The pharmacy had also carried out a full medicines audit at the home . The acting manager confirmed that, although there was a suitable refrigerator available in the medicines room, stocks of medicines for certain emergencies were stored in the refrigerator in the kitchen which was not secure. They told us that this was because it would prevent delays in the event that an emergency occurred.

We noted that the acting manager had carried out two audits of medicines. However, these appeared to have been limited to the correct completion of the medicines administration records (MAR), and did not include a stock reconciliation. We found there were large stocks of some medicines held. There was a risk that medicines could become out of date before they were used.

There was therefore a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We had received information alleging that people had been subjected to abuse by care staff, this had been investigated by the local authority and action taken against the perpetrator. However we were also alerted to an allegation of theft in the home had not been appropriately reported. We shared this information with the local authority safeguarding team

Although there was a safeguarding policy in place and clearly displayed, not all staff were aware of their responsibilities. One of the care workers told us told us that they had received training on safeguarding. They said that if they suspected that people were being abused they would report this to the manager, but they were not aware that they could also report their concerns outside of the organisation. We also found that this staff member did not understand us when we asked them about the different types of abuse people may suffer. However, the remaining care workers we spoke with had received training and were able to clearly explain the types of abuse that they needed to be aware of and their responsibility to protect people.

Inadequate

Is the service safe?

People were not protected against the risk of harm and this was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

Some people who lived at the home were living with dementia and lacked the mental capacity to make decisions on their care. We looked at the care records of one person who was living with dementia. We found that there had been no assessment of their mental capacity to make decisions for themselves. There were also no records to show that decisions about their care had been made in their best interest in accordance with the Mental Capacity Act 2005.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information that staff lacked the required skills to care for people effectively. Staff told us that they had received training in respect of the correct way to support people who required assistance to move around the home. However, we witnessed someone being supported incorrectly and in such a way that could have caused them injury to move from a wheelchair to a chair in the lounge. The acting manager also witnessed this operation and questioned the two staff members on their actions. Another person's care plan stated that they should have two care workers to assist them with personal care and walking. However, they told us that this never happened and they only ever had one care worker available to support them with these activities.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information that people were receiving poor quality food. However, people told us that they enjoyed the food they received. One person said, "The food is good. I still enjoy it. For the first time since I have been here they came round and asked if I would like a change for my breakfast. I had bacon and fried tomatoes instead of the toast I normally get. They don't normally do cooked breakfast. It is usually cereals or toast. I am allergic to milk so they get me soya milk." Another person said, "My only complaint is that breakfast and dinner is a bit close together and I can't always eat it. Like today, breakfast of bacon and tomato at about nine and then a big dinner at 12. It's too much." When asked what was for lunch people were unable to say. One person said, "I don't know, it will be a meat based thing, and maybe pie, I don't really know but the food is lovely."

The registered manager, who cooked the meals on week days, was very knowledgeable about people's dietary needs and their allergies. However there was no information in the kitchen for staff who cooked the meals at weekends to refer to. Therefore there was a risk that people's specific dietary requirements were not always considered. One person told us that although they had diabetes they were given toast with marmalade very often for their breakfast. This caused their blood sugar levels to spike after they had eaten it. We saw that the record of their blood sugar level showed that it was higher than the recommended level but were assured that this was still within a safe range for them.

We looked in the food cupboards, fridges and freezers and saw that food supplies were plentiful with fresh fruit and vegetables were available in good quantities. Biscuits were available in the dining area all morning for people to have whenever they wanted. We saw that the menus catered for a variety of cultural needs, with curries included. We saw yams and ackee in the kitchen ready for preparation.

We noted that where people needed assistance to eat their meals staff provided support to them in an unhurried way. However we saw little interaction between the staff and the people they assisted to eat their meal. Staff did not explain to people what they were eating or attempt to talk with them during their meal.

We saw that one person received a diet of very soft foods. We were told that they were unable to eat solid food. However there was no documentation within their care records to show that this was their choice or in accordance with professional advice. There was nothing to show that the person had been referred to the speech and language therapist (SALT) or the dietician. The diet that they received may not therefore have been suitable for their needs.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Is the service caring?

Our findings

We did not look at this question during this focussed inspection.

Is the service responsive?

Our findings

We did not look at this question during this focussed inspection.

Requires improvement

Is the service well-led?

Our findings

The acting manager of the home had been in post for seven weeks at the time of our inspection, and had now resigned from their post. The registered manager, who is also the provider, spent their much of their time in the kitchen. The acting manager highlighted a number of issues of poor practice to us but we were unable to find any evidence to substantiate the claims on the day of our inspection. We observed that there was little interaction between the two managers when we spoke with them together. The acting manager appeared to be unsupported by the registered manager which made it difficult for them to manage the service effectively.

The records and data management systems were not robust. A care record we looked at showed that a person occasionally displayed behaviour that challenged others. Their care plan and risk assessment described what staff should do to calm the person if they displayed such behaviour. The record also contained a document on which such incidents should be recorded; together with information as to what the person was doing immediately before the incident occurred. Although there were entries in the daily diaries that showed such incidents had occurred the document on which they should have been recorded was blank. The staff were therefore unable to identify any triggers for the person's behaviour to reduce the risk to other people at the home.

We also saw that the acting manager was in the process of implementing new care records for people. Some people's records had been transferred to the new system. We looked at one record for people from each of the two systems. We found that whilst the new records were an improvement on the old system the information contained within it was at times inaccurate and did not reflect the person's individual needs well. We found that the record of delivery of personal care to be inaccurate. The narrative daily records contained information of personal care that had been delivered but had not been recorded on the relevant document. The records were not therefore accurate.

The acting manager told us that the staff delivering care did not complete the records of the care that had been delivered. These were completed by the acting manager or the senior care worker. As the records were not completed until sometime after the care had been delivered there was a risk that the information recorded was inaccurate. Some records we looked at, such as the night time checks and records of when people had been moved to prevent damage to their skin, had been recently introduced by the acting manager. We saw that these had been fully completed.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider had failed to take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider failed to operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character and failed to ensure the requirements of Schedule 3 were met. Regulation 19 (1) (a), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 CQC (Registration) Regulations 2009 Financial position The provider failed to protect people against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, safe keeping, and safe administration of their medicines. Regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider failed to ensure that people are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and failing to respond appropriately to any allegation of abuse. Regulation 13 (2) and (3)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider failed to take proper steps to ensure that care was provided in a safe way. Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider failed to have suitable arrangements in place for establishing, and acting in accordance with, the best interests of people. Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider failed to ensure that people are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of them which shall include

This section is primarily information for the provider

Action we have told the provider to take

appropriate information and documents in relation to the care and provided. Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.