Aspire Care (UK) Limited

Fawnhope Rest Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 24 and 25 May 2016 and was unannounced.

Fawnhope Rest Home is registered to provide accommodation and personal care services for up to 19 older people, and people who may be living with dementia, a learning disability or other mental health condition. At the time of our inspection there were 16 people living at the home. They were accommodated in a converted and extended residential building with a shared lounge and dining area. One person was accommodated in a separate annexe intended for people with greater independence. At the time of our inspection they chose to have their meals and daytime activities in the main house. There was an enclosed garden.

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

Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided. However the provider did not always make sure that required maintenance to the building and equipment was arranged in a timely manner. They had not completed maintenance actions identified in a fire safety audit. The provider relied on informal systems of management in some areas.

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure only workers who were suitable to work in a care setting were employed. Arrangements were in place to store medicines safely.

Staff received appropriate training and supervision to maintain their skills and knowledge. Staff were aware of the need to gain people's consent to their care and support. Staff were aware of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They did not apply to anyone living at the home at the time of our inspection.

People were supported to eat and drink enough to maintain their health and welfare. They were able to make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs. People were supported to access healthcare services, such as GPs and community nursing teams.

People told us they had caring relationships with their care workers. They were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's individuality, privacy, and dignity.

The provider involved people in the care assessment and care planning processes. Care and support were based on plans which took into account people's needs and conditions, but also their abilities and preferences. Care plans were updated as people's needs changed, and were reviewed regularly. People were able to take part in leisure activities which reflected their interests. Group activities and entertainments were available if people wished to take part.

The home had an open, friendly atmosphere in which people felt able to make their views and opinions known.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we told the provider to take at the end 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?

Good

The service was safe.

People were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and checked they were suitable to work in a care setting.

Processes were in place to make sure medicines were handled safely.

Is the service effective?

Good

The service was effective.

Staff were supported by training and supervision to care for people according to their needs

Staff sought people's consent to their care and support. Staff were aware of their responsibilities where people might lack capacity to make decisions.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

Is the service caring?

Good

The service was caring.

There were caring relationships between people and their care workers.

People were listened to and were able to participate in decisions affecting their care and support.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care and support were provided in line with plans and assessments which took into account their needs and preferences. Care plans were changed as people's needs changed and were reviewed regularly.

There was a complaints procedure in place, but most concerns were dealt with on a day to day basis.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not carried out all required maintenance in a timely fashion.

A management system and processes to monitor and assess the quality of service provided were in place. In places the management system was informal.

There was an open, friendly culture in which people were treated as individuals and encouraged to speak up about their care and support.

Fawnhope Rest 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 24 and 25 May 2016 and was unannounced. The inspection team consisted of an inspector and an inspection manager.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who lived at Fawnhope Rest Home, two family members and two other visitors to the home. We observed care and support people received in the shared area of the home.

We spoke with the registered manager, the registered provider and two care workers. We looked at the care plans and associated records of three people. We reviewed other records, including the provider's policies and procedures, internal checks and audits, quality assurance survey returns, training and supervision records, staff rotas, menus, accident forms, and recruitment records for three staff members.

Good

Is the service safe?

Our findings

People told us they felt safe and comfortable at the home. Visiting family members were confident their relations were safe. One visitor said, "No problems at all. I am confident [Name] is safe. She gets 24/7 care. They phone straight away if there is any problem."

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the registered manager.

The registered manager was aware of processes to follow if there was a suspicion or allegation of abuse. We discussed one incident which they had investigated and reported to the local authority who had decided there were no safeguarding concerns related to the incident. There were records of two other incidents where visiting healthcare workers had raised concerns about accidental injuries caused in the course of treatments they were providing. One person developed a pressure injury under a dressing. The other incident involved bruising trauma following a blood pressure check. Neither of these involved actions by staff at the home. The manager had reported the incidents to the local authority who judged these incidents did not need to be investigated as safeguarding concerns.

Suitable procedures and policies were in place for staff to refer to, including external organisations they could contact if their concerns were not addressed internally. The registered manager had produced information about the signs of abuse in picture form for people who found pictures easier to understand than text.The registered manager and registered provider kept up to date with issues relating to safeguarding. They had both recently attended a workshop organised by the Hampshire Safeguarding Adults Board. This is a multi-organisation partnership led by the county council to co-ordinate adult safeguarding across the county. The passed information on to staff by means of information leaflets produced by the board.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with poor nutrition, falls and people going outside the home. One person's care plan contained the entry that the person's appetite was poor since they were discharged from hospital. Guidance was in place for staff to encourage them to eat and drink enough. A standard tool and method was used to assess people's risk of developing a pressure injury. Where risks were identified, action plans were in place for staff to reduce the likelihood of the risk and to manage any risks that occurred. The registered manager had produced small cards to identify that the person lived at Fawnhope Rest Home with the home's telephone number in case people needed assistance when outside the home. Staff we spoke with were aware of techniques and strategies to "defuse situations" arising from people's frustrations.

Procedures were in place to keep people safe in an emergency and reduce risks to their health and welfare. The registered manager had carried out risk assessments for people's rooms and the shared areas of the home. Actions identified in these risk assessments were carried forward into the home's maintenance plan,

for instance there was an action to repair the floor in a shared bathroom. There was an emergency plan if staff needed to evacuate the building. This was tested regularly, with the most recent test taking place after it had got dark to test a night-time evacuation. People had personal emergency evacuation plans which took into account their individual mobility and any communication needs. Their evacuation procedure was available in people's rooms in a large print format.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff, and staff told us their workload was manageable. The registered manager told us staffing levels were based on people's needs and dependency. At the time of our visit most people living at the home were quite independent. The names of staff on duty were displayed in the dining room. This information and rotas showed that the standard staffing level at the time of our visit was three care workers on each shift. This was in addition to the registered manager, cleaner and cook. We saw staff were able to carry out their duties in a calm, professional manner. If people needed more than one care worker to support them, this was arranged promptly. The registered manager and staff told us that more care workers were brought in if needed, for instance if people were ill, or required one to one care.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. The registered manager told us they did not use agency staff but had a stable work force they could call on when required.

Procedures were in place to make sure medicines were stored and handled safely. People's medicine administration records were accurate, up to date and reflected information in the person's medicines care plan. Where people were prescribed medicines to take "as required" there were specific instructions for the care workers. Care workers noted the time and dose administered for "as required" medicines which meant there was a full record of what people had taken.

Care workers received specific training and had their competence confirmed by the registered manager before they supported people with their medicines. The registered manager carried out a weekly audit of medicines. Where we observed care workers supporting people with medicines, they gave the person their tablets with a drink to take themselves. They remained with the person until they had taken all the tablets. During the inspection we saw that a person had an unidentified tablet in their purse. A care worker took the tablet and reported it to another staff member for investigation. The person's records showed they had taken all their medicines that morning. It was not possible during the inspection to confirm how long the tablet had been in their purse or where it had come from.

The provider's pharmacist had carried out an audit of medicines procedures and records within the previous year. There were no actions arising.

Good

Is the service effective?

Our findings

People living at Fawnhope Rest Home and their visitors were confident staff had the skills and knowledge to support them according to their needs. A visitor told us, "They look after you well here." When we asked people about staff, their comments included: "Staff are marvellous," "Employees are very good here," "They are good at grounding me," and "Staff not too bad, one or two are bossy."

Staff were satisfied they received appropriate and timely training and had regular supervision meetings with a senior staff member. They told us they had induction training which prepared them to support people according to their needs. There was regular refresher training in subjects the provider considered mandatory, such as safeguarding, infection control and health and safety. One care worker told us they were aware there was a "big list" of refresher training coming up.

The registered manager had an effective system for monitoring staff training. Their records showed clearly where staff had completed training, where it was due and where it was overdue. There was a backlog of scheduled training following problems with the provider's supplier, but the provider had made arrangements to catch up with mandatory refresher training in the coming months.

Staff had annual appraisals and four to six supervisions a year. The registered manager had delegated staff supervisions to a senior staff member. Supervision meetings were structured according to certain subject topics such as personal care, "toileting and bathing", medication, standards of the home, and "general attitudes". Staff told us they felt there was an effective system of formal and informal support. One care worker said they could "go to the manager for anything".

The registered manager had reviewed the Care Certificate with staff to identify how they could apply it to Fawnhope Rest Home. The Care Certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care.

The Mental Capacity Act 2005 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 the least restrictive 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 Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Act.

Staff assumed people had capacity. The provider had a process and forms to complete when assessing a person's capacity which conformed to the principles of the Act. At the time of our visit there was nobody living at Fawnhope Rest Home who had been assessed as lacking capacity. The registered manager and

staff told us that everybody was able to communicate their consent to care and support. As a consequence there had been no need to apply for Deprivation of Liberty Safeguards. One person we spoke with said, "I can go out if I want to."

Signed records were in place to show people had consented to their care plans. These included records of consent to share information, for the administration of medicines and for personal care.

People were supported and assisted to maintain a healthy diet. People were complimentary about the food provided. One said, "It is OK here. You can have hot food or sandwiches." There was a daily menu with an alternative choice available. We heard staff discussing sandwiches with a person as an alternative to the hot meals offered. Staff offered people choices of hot or cold drinks and snacks. People could have a later breakfast if they wanted to. We saw lunch being served. The menu looked and smelled appetising. People did not have to wait for their food, and the atmosphere at lunchtime was pleasant and unhurried. Fruit and cold drinks were available throughout the day.

Staff were aware of people's food preferences, any allergies and individual needs, such as for people who were living with diabetes.

People could access healthcare services when needed to support their health and wellbeing. These included people's GP, community nurses, older people's mental health team, social services and dentists. Records showed people were supported to attend hospital outpatient appointments and other services such as a falls rapid assessment unit.

Good

Is the service caring?

Our findings

There were caring relationships between people and staff who supported them. People described staff as "a nice crowd", and visitors told us they appreciated the atmosphere at Fawnhope Rest Home and the way staff interacted with people. We heard conversations between people and staff which indicated caring relationships. One person said to a care worker, "I like you." The care worker replied, "I like you too." Another person said to their care worker, "You are a good girl."

Staff knew people's preferred names and were aware of their needs. They addressed people in a kindly, respectful way, offered them choices and respected their choice if they declined help. Staff spoke clearly, made eye contact with the person they were talking with, and gave people time to understand and reply. When they helped a person sit in the shared lounge, they made sure they were comfortable before moving on. Staff responded quickly when a person appeared to fall asleep in an uncomfortable position and when a person coughed or cleared their throat. They checked the person was OK and offered them a drink or snack. We saw that the relative of a person who was hard of hearing spoke to the person on their better side and spoke clearly so they could understand. We later saw a care worker speak to the person in the same way.

The registered manager was aware that some staff had been affected by the recent deaths of certain people who had lived at the home for a long time. They had compiled memory books, which had been helpful for both staff and other people who missed them.

Staff supported people to express their choices and take part in decisions about their care and support. One care worker said, "People can do what they want. There is no schedule." We heard one person tell a care worker they were hungry. The care worker supported them to move to the dining room to get something to eat.

The registered manager had developed a "charter of rights" which explained to people what they could expect from the service. This was displayed in their room. There were also "room procedures" which explained to staff how people liked them to behave when they were in the person's room.

Staff explained people's care plans to them, and asked for people's consent when it was time to review and update people's plans. People and their families took part in the care plan reviews and signed to show they had been involved.

The registered manager had prepared pictures to help people who had difficulty explaining their choices verbally. These included pictures of food choices, different mobility aids, and visual prompts, for example for the bathroom. There were also visual prompts if required to help staff explain mental capacity and the types of abuse. People's rooms had a picture on the door of an object or person that was important to them. This helped people orientate themselves and recognise their own room. Inside people's rooms a picture of a cherub was used to remind staff and paramedics if there was a "do not resuscitate" form in place for the person. This was a sensitive way of making sure staff could respond promptly and in accordance with people's wishes.

Staff respected people's dignity and privacy. Care workers gave us examples of how they respected people when supporting them with personal care. Where people shared rooms, there were screens to preserve people's privacy except where the two people in the room did not want them.

A "dignity in practice" file was available for staff to refer to. It was the result of an exercise to show how respecting people's dignity was linked to all areas of people's care and support. It included guidance for respecting and involving people, supporting them with personal care and welfare, meeting nutritional needs, complaints, cooperating with other providers, safeguarding, and cleanliness and infection control.

Staff told us nobody living at the home had particular needs or preferences arising from their religious or cultural background. They were aware of some of the adjustments to people's support that could arise from this. Equality and diversity was included in regularly refreshed training. Representatives from a local church provided a regular act of worship for people who wished to attend. Staff told us people's family members often joined in to share the worship with their relation.

Good

Is the service responsive?

Our findings

People received assistance with their personal care that met their needs and took into account their preferences and wishes. One person told us they were able to follow their own preferred routines. They said, "We get to pick what to do." Another person's visitor told us, "[Name] is very happy here. Nothing is too much trouble for the staff. [Name's] mobility has improved."

People's care and treatment were reviewed regularly and changes made if required. There were weekly feedback forms to record temporary changes to people's care plans, such as if the person was prescribed a course of antibiotics.

Monthly checks, for instance on people's weight, were made if appropriate. Standard screening tools, for instance if people were at risk of poor nutrition, were used monthly. One person's care plan had been amended in response to a consultation at a falls clinic. The provider had worked in cooperation with the clinic to review the person's medicines. There were no falls recorded for the person in the five months before our inspection.

Care plans were based on pre-admission assessments designed to identify people's needs and preferences. The registered manager had developed new forms to guide the assessment process and focus it on the person as an individual. These were called "Information to start my care plan" and "My fondest memories".

Care plans were individual to the person and followed a template which recorded the person's abilities, their desired outcomes and actions for the care workers to support them in meeting their needs. In addition to their "care profile" there was information about the person's communication needs, their life story and family tree showing people who were important to them. The service gathered information about people's preferences with respect to their food choices and activities to maintain their interests and hobbies. Staff told us the care plans contained the information they needed to support people according to their needs and preferences.

Staff supported people in line with to their agreed plans. The support people received was recorded in a "shift report". Staff kept appropriate records if people's care included hourly observations, night checks and monitoring of people's food and fluid intake.

People could take part in a variety of activities and entertainments. The provider linked shared activities with events outside the home such as seasonal holidays and national events such as "Comic Relief". On the day of our inspection, there was an event in support of a national charity's fund raising month. People were engaged with staff and visiting family members to prepare for the event, decorate the shared areas of the home, and take part in the afternoon entertainment.

There was a programme of entertainment and activities which included music and reminiscence, pets as therapy, music, cooking, and worship on Sunday. People had enjoyed excursions to a nearby zoo, parks and historical buildings. There had been trips to a fish and chip restaurant and a tea dance.

Visitors told us there was something for people to do every day, and staff told us how they could encourage people to maintain their hobbies and interests. These included shopping, knitting and gardening. One person looked forward to musical entertainments as they were an opportunity to dance. Staff had discovered another person enjoyed a particular performer's music and they obtained a DVD film of the performer's life story. Another person told us they liked the fact that the home was "close to town" and they could go out to the shops.

People were confident any concerns they raised would be dealt with promptly and effectively by the registered manager. The manager told us they dealt with minor concerns on a day to day basis before they became a formal complaint. We saw the records of an incident which had been treated by the provider as a complaint. It had been investigated, followed up and the outcome communicated to the person's family.

The provider's complaints procedure was on display near the entrance to the home. It was also available in a picture format for people who found a visual format easier to understand.

The registered manager told us no other complaints had been logged recently. We saw there were a number of thank you cards and compliments. The manager told us these were displayed in the shared area of the home for a period and then moved to their office. This allowed staff and people living at Fawnhope Rest Home to be aware of positive comments received about the service they provided.

Requires Improvement

Is the service well-led?

Our findings

Hampshire Fire and Rescue Service had carried out a routine fire safety audit of the home in October 2015. Their report had identified four actions which the provider was required to complete by dates between 1 December 2015 and 1 March 2016. At the time of our inspection, two of the actions had been completed, but two had not been completed by the date in the report. The provider told us they had started the process of obtaining quotations in March 2016 and expected their supplier to be on site in June 2016 to carry out the necessary works. A further action had been addressed, but there was no record to show the works had been done to the required standard. After our inspection the provider informed us they had been in touch with the fire officer to inform them of the delays in taking the action identified. Hampshire Fire and Rescue Service confirmed to us that they had agreed an extension to 1 July 2016 for completion of the outstanding items. However on 9 August 2016 the Service had not received confirmation from the provider that works were complete. The provider told us they had received the correct documentation from their contractor on 8 August 2016 and had forwarded it to Hampshire Fire and Rescue Service.

Failure to make sure that premises and equipment were properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found the management style was appropriate to the size and atmosphere of the home. Appropriate records were kept in most areas, but in some areas the approach was more informal with no records. This made it difficult for the registered manager to demonstrate how they dealt with complaints and concerns, and how they analysed and followed up incidents and accidents. One person told us they had recently hurt their foot. Staff confirmed this had happened and the person was receiving treatment for the pain. There was a record of the accident in the "Shift Report Form" and of treatment by the community nurse in the "Doctors Visit Log". However, there was no accident report completed and no records to show how the manager investigated the cause of the accident and learned appropriate lessons.

There was an open, inclusive atmosphere in the home. The registered manager and provider spent time in the shared areas of the home, talking to people. They knew people by name, and people responded to them positively. People described the service as "a home from home" with a "fantastic manager". A visitor told us, "The manager is very good and they have already got a lot of information about [Name]."

The registered manager told us because Fawnhope Rest Home was a "small service" with a stable, long-standing group of staff, they were able to reinforce the service's core values through regular formal and informal contact with staff. These core values were: privacy, choice, independence, dignity, rights and fulfilment. Staff we spoke with agreed that there was an open, sharing culture in the home. One care worker said, "The manager has an open door. We can all voice an opinion."

The registered manager's management system included monthly meetings with both staff and people living at the home. These were minuted and actions identified were followed up, for instance following a meeting the provider used a donation to purchase a new CD player for the service. Meetings also gave people the opportunity to comment on changes to the tea time meal menus and new decoration in the home.

The manager used staff meetings to increase staff awareness of topics, such as mental capacity and dementia care, by means of quizzes and the discussion of scenarios to relate the topic to people living in the home. The manager had prepared guides and information for staff. These included an "aide-memoire" about mental capacity which reminded staff of the key points on a conveniently sized card they could carry around or use as a bookmark.

The manager had delegated staff supervisions to the care development coordinator. The manager kept in touch with staff performance by informal and formal observation of care. The formal observations covered dignity, respect, listening to people's wishes, time spent and support with personal care.

On each shift one care worker was the designated "care planner" with additional responsibilities. These responsibilities included making sure records were completed where people were supported to reposition themselves regularly or had their fluid intake monitored. The care planner also made sure people in their rooms were supported according to their plans and that there was cover in the shared area of the home. They were responsible for reporting to the manager and for shift handovers.

There was a system for monitoring and improving the quality of service provided. There were internal checks and audits which covered the physical environment of the home, infection control procedures, cleaning records, and the administration of medicines. The registered manager responded to actions arising from these checks. For instance, when checks showed the medicines fridge was showing high maximum temperatures it was replaced.

The registered manager had completed a questionnaire developed by a national charity for residential care services to assess their environment from the point of view of people living with dementia. Following this self assessment, they had put up pictures of people and subjects intended to promote reminiscence. They also kept up to date with developments in the care sector through membership of an association for providers of residential care services which offered workshops and seminars on a variety of subjects.

The registered manager gave people and staff the opportunity to comment on the quality of the service by means of survey questionnaires. The staff survey was completed by 100% of staff, although some people declined to take part in their survey. The manager told us they said they were happy with the service and would simply tell the manager if they were not.

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 15 HSCA RA Regulations 2014 Premises and equipment The service provider did not ensure that all premises and equipment used were properly maintained. Regulation 15 (1) (e)