Fairfield Care (West Dorset) Limited

Fairfield House

Inspection report

41 Putton Lane
Chickerell
Dorset
DT3 4AJ

Tel: 01305779933

Date of inspection visit:
26 February 2018
05 March 2018

Date of publication:
16 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26 February 2018 and was unannounced. The inspection continued on 5 March 2018 and was announced.

Fairfield House 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 care home accommodates up to 16 people across two floors. The service is located in Chickerell and is a detached building with rooms arranged over two floors and a ground floor lounge and dining area. There is lift access to the first floor. People are able to access secure outside space at the home. There were 16 people living at the home at the time of our inspection.
The majority of people living at the service had dementia or mental health diagnoses. Most people were unable to speak with us to tell us about living at the home so we gathered this information from relatives and through observation.

Fairfield House had 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'. 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.

Quality assurance measures did not provide oversight of all areas of the service. This meant that issues relating to respectful practice, DoLS monitoring and training had not been identified. The registered manager was working with the provider to ensure full oversight of the service provided and ensure that actions were planned to drive improvements.

People were supported to make choices about all areas of their support. There were capacity and best interest's decision in place however these were not always in line with the Mental Capacity Act good practice guidance. We have made a recommendation about assessing capacity in line with MCA.

Staff did not always use language or interact with people in ways which were respectful. The registered manager told us that they would ensure that staff culture was respectful of people in both language and body language.

Interactions with people were generally kind and friendly and relatives told us that they had peace of mind that their loved ones were receiving safe, compassionate care.

People were supported by staff who respected their individuality and protected their privacy. Staff understood how to advocate and support people to ensure that their views were heard and told us that they would ensure that people's religious or other beliefs were supported and protected. Staff had undertaken

training in equality and diversity and understood how to use this learning in practice.

People and those important to them were involved in planning the support they would receive and also regularly asked for their views about the support and any changes to people's needs. Reviews identified where people's needs had changed and reflected changes to the support provided in response to this.

People were supported to have one to one time with staff in social activities. Visitors were welcomed at the home and kept up to date about how their loved ones were.

People were supported to have enough to eat and drink and there were systems in place to ensure that any concerns around weight loss were monitored. People's preferences for meals were well known and choices were offered if people did not want the meal provided.

Staff were also aware of the risks that people faced and understood their role in managing these to ensure people received safe care. Risks around behaviours that could challenge recorded in people's care plans where appropriate and understood by staff.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care. Medicines were stored and disposed of safely and accurately recorded.

People were supported to receive personalised, compassionate end of life care and their wishes and preferences were recorded.

People were supported to access healthcare professionals when required and the service worked with a number of external agencies to ensure that people received joined up, consistent care.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training to ensure that they had the necessary skills and knowledge to meet people's needs. The registered manager told us that they would ensure oversight of additional training to ensure staff completed topics which were relevant to people's needs.

People were protected from the spread of infection by staff who understood their role in infection control and used appropriate Personal Protective Equipment (PPE).

Staff were confident in their roles and felt supported by the manager.

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

Risks people faced were managed by staff and reflected in people's care plans.

Medicines were managed safely, securely stored and correctly recorded.

People were supported by sufficient numbers of staff who had been recruited with safe pre-employment checks.

People were protected from the risks of abuse by staff who understood the potential signs and were confident to report.

People were protected from the spread of infection by staff who understood the principles of infection control.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Requires Improvement

The service was not always effective.

People were asked to consent to their support but assessments of capacity and best interest decisions were not always in line with good practice guidance.

Staff received supervision and training in topics the service considered essential but there was no system in place to ensure staff undertook training in other topics relevant to their role.

The service worked with other healthcare services to deliver effective care.

People's needs and choices were assessed and effective systems were in place to deliver good care and treatment.

People were supported in an environment which was adapted to meet their needs.

People were supported to eat and drink enough and concerns about weight or fluid intake were effectively managed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Language used by staff and interactions with people were not always respectful and the registered manager told us that they would address this.

Staff knew how people liked to be supported and offered them appropriate choices.

Visitors felt welcomed at the service and visited whenever they chose.

People and their relatives were listened to and felt involved in making decisions about their care.

People were supported by staff that respected and promoted their independence, privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were engaged in social opportunities which were personalised and had one to one time with staff.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

People received person centred, compassionate end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems did not provide effective oversight of the service. The registered manager was working with the provider to improve these systems.

Staff felt supported and understood their roles and responsibilities within the service.

The service was led by a management team which was approachable and feedback was positive from people, relatives and staff.

Feedback was sought through meetings and informal discussions and used to drive improvements.

The service worked in partnership with other agencies to ensure that people received joined up care.

Fairfield House

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.

The inspection took place on 26 February 2018 and was unannounced. The inspection continued on 5 March 2018 and was announced. The inspection was carried out by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority to obtain their views about the service.

We had not requested a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during to the inspection.

During the inspection we spoke with two people who used the service and three relatives. We also spoke with six members of staff, the registered manager and the provider. We spoke with two professionals who had knowledge of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection, these included five care records. We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments, meeting minutes and staff training records. We looked at three staff files, the recruitment process, complaints, training and supervision records.

Good

Is the service safe?

Our findings

People and relatives told us that staff provided safe support and we observed people being supported safely during our inspection. One relative explained "I have peace of mind that (name) is safe, I know (name) is being looked after". Another explained "I'm quite happy that (name) receives safe care". We observed that people had been supported to sit safely in specialist chairs and that where someone was being assisted to eat in their bed, staff had adjusted the back to ensure they were in a safe position to eat their meal.

People understood how to protect people from the risks of abuse and how to report any concerns. One staff member explained that they would be "looking for any bruises or any difference in their behaviour". They explained that because they knew people well, they would be able to identify more subtle signs of concern and would be confident to raise any alerts if needed. The service had not had any safeguarding concerns raised in the 12 months prior to this inspection but the registered manager understood how and when concerns would need to be raised.

People understood the risks people faced and their role in managing these. People had person centred risk assessments which identified what risks staff needed to be aware of when supporting people and actions required to support people safely. For example, one person was assessed as being at high risk of falls. Actions taken included considering whether sensor mats and an adjustable height bed were required to manage this risk. Another person had developed some risks around swallowing food. Staff had recognised this and involved the person's GP. We saw that the person's diet was changed to ensure that they were able to eat safely. This risk was reflected in the person's care plan and on staff handover information to ensure that all staff were aware.

People were supported by sufficient numbers of safely recruited staff. The registered manager told us that they used a dependency tool to identify how many staff needed to be deployed to meet people's assessed needs. Staff told us that there were generally enough staff to respond to people in a timely way. We observed that where people used call bells, these were responded to without delay during our inspection. Recruitment at the service was safe with appropriate pre-employment checks in place. Staff files included references from previous employers, identification checks and application forms. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. The registered manager was in the process of recruiting qualified nurses and any outstanding shifts were covered by existing qualified staff. Agency staff were rarely used and the registered manager explained that most recruitment came through word of mouth and recommendations.

Staff had access to enough suitable equipment to assist people safely. This was maintained regularly and staff explained that equipment was available on both floors of the home to ensure that this was easily accessible for staff and did not delay support for people.

Some people living at the home had behaviours which could challenge. Care plans included information about what could cause people to become upset and whether there were any particular trends or patterns.

For example, one person was likely to be more anxious at a particular time of day. If there were known triggers to a person becoming upset, these were recorded and actions to settle the person were documented. Where people posed a risk to themselves or others, this was recorded by staff and shared with external professionals to consider the best approaches to support the person.

Fire evacuation procedures were in place and each person had a personal emergency evacuation plan (PEEP). These detailed what support people would need to evacuate the premises safely. There were regular safety checks on fire alarms and fire exits and maintenance issues were recorded and resolved promptly.

People were supported in an environment which was kept clean and safe with regular monitoring checks and cleaning. There were regular housekeeping staff who ensured that all areas of the home were kept hygienic and people were protected from the risk of infections. Availability of suitable personal protective equipment (PPE) such as gloves and aprons was monitored to ensure there were sufficient supplies and all staff had received training in infection control. People told us that staff used gloves when they supported them and we observed staff using gloves and aprons when assisting people with their meals and drinks also. One person explained "it's really clean here, they (staff) wear gloves and aprons".

People received their medicines as prescribed and these were recorded accurately in people's Medicines Administration Records (MAR). People were asked if they wanted medicines which were prescribed 'as required' and where people were unable to tell staff if they were in pain, there were pain assessment tools in place. Some medicines required additional security and we saw that these were in place and stock was regularly checked and double signed by staff. The service had recently changed to use blister packed medicines which staff who administered medicines felt this was a positive change and reduced the time taken to complete a medicines round. The service had safe arrangements for the ordering, storage and disposal of medicines. Some medicines required colder storage and this was provided with regular temperature checks in place.

Staff understood their responsibilities to report concerns or incidents and the registered manager explained that any learning was shared with staff. They gave an example about managing a performance issue and explained that when they had discovered that there were issues with paperwork, they had met with staff to discuss the lessons learnt and how to ensure that the situation was not repeated. They also explained that when they monitored accidents and incidents, any trends or patterns were share and discussed with staff to consider any possible causes or actions needed.

Requires Improvement

Is the service effective?

Our findings

People had pre-assessments in place which formed the basis of their support plans. These considered what support people required and their preferences. Information in these initial assessments was discussed with people and those important to them so that the service were able to identify whether they would be able to effectively meet the person's needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection we had identified assessments of people's capacity as an area for improvement and this had also been identified with the service by the local Clinical Commissioning group as part of their monitoring. During this inspection we found that assessments of people's capacity were not all decision specific and in some cases, best interest's decisions were recorded for people on dates before their capacity had been assessed. This was not in line with MCA good practice guidance. Some capacity assessments referred to legal powers held by relatives of people. Where it was indicated that someone had a legal power to make decisions on the person's behalf, best interest's decisions had still been recorded. However it was not consistently clear whether legal powers held for people related to the decisions which had been made. The registered manager told us that they were in the process of reviewing and amending the MCA and best interest's decisions and had completed some of these before our inspection. We saw that some had been completed but that some of the identified issues still remained.

We recommend that the provider considers good practice guidance to ensure that the service understands and meets the requirements set out in the Mental Capacity Act 2005.

Where people required applications for DoLS to be made, these were in place and the registered manager told us that one person's authorisation had expired so they were in the process of making a further application. Where one person had a condition attached to their DoLS authorisation, this had been met.

Staff received training in some areas which the service considered essential, however there was no oversight about what additional training was relevant for staff to complete to ensure that they had the correct knowledge and skills to support people. Essential areas for training included moving and assisting, infection

control, communication and fire safety. The registered manager explained that staff had access to a range of online training topics and they showed us certificates for training staff had completed. Additional training included continence and catheter care, dementia and behaviours that challenge. There was no guidance or system in place to identify and ensure that training completed was relevant for the people living at the service. This meant that staff had access to training but this was not designed around staff learning needs and the care and support needs of people who used the service. The registered manager told us that they would consider and consult staff to agree what training would be relevant for people and ensure that staff completed these.

Qualified nursing staff had access to relevant training to maintain their professional registration. They told us that they received support to re-validate with their professional body, the Nursing and Midwifery Council (NMC). Nurse re-validation is a requirement of qualified nurses. This process ensures they provide evidence of how they meet their professional responsibilities to practice safely and remain up to date. The registered manager told us that qualified nursing staff received clinical supervision from the provider on a regular basis. One qualified nurse told us that they regularly discussed practice at handovers and planned meetings and received support from the clinical lead at the home. Other staff also received regular supervision and annual appraisals. Staff told us that supervision was used to discuss practice and any learning or development issues.

People were supported to receive enough to eat and drink and the chef was aware of people's dietary needs and any allergies. The chef was able to confidently tell us about people's likes and dislikes and explained that if people did not want the main meal offered, they would make something else for them. The menu was planned by the registered manager and reflected people's preferences. Where menu options were not popular or disliked, these were removed and the chef provided examples of options which had been taken off the menu because of this. Where one person had a small appetite, the chef explained how they offered the person choices of foods they knew were the person's favourites to encourage them to eat. Some people had adapted cutlery to manage their meals independently and another person had a smaller portion because this suited them better.

If people needed foods to be prepared in a particular way to eat safely, this was provide and the chef had copies of safe swallow plans for people which gave guidance from professionals about what foods people could safely eat and how these should be prepared. One person told us that the food was always good and they had choices about their meals. Another person told us about what they liked to eat and that their choice of foods was respected and prepared for them. A relative explained that their loved one was eating really well with support from staff.

Care plans included important information about people on a single sheet which was at the front of people's files. This was then be used to ensure that if a person was admitted to hospital, information about their needs could be effectively shared. This included information about people's mental health and signs that this could be deteriorating if they were in an unfamiliar environment with staff who did not know them well.

People were supported to access different areas of the home to meet their individual needs. One person used outside space regularly and was given the key pad code to use so that they could do this independently. The home had an accessible garden and we saw one person using this during our inspection. People's rooms had details and pictures which were personal for them and pictorial signs were used to identify bathrooms and toilets. People had personal items in their rooms, including furniture, pictures and ornaments to ensure that these were personalised.

People had access to healthcare services when required. We saw that people's care plans included involvement of a range of professionals including Mental health teams, GP's and speech and language therapy. One professional told us that staff provided them with a good handover about each person they were visiting and said that the service contacted them for advice and support appropriately. Another professional also said that the service sought advice where needed and that referrals were promptly actioned and advice followed by staff.

Requires Improvement

Is the service caring?

Our findings

People were not consistently supported by staff who were respectful in their use of language or approach with people. We observed several people sat in the dining room at lunchtime, there were five members of staff who were stood around the dining table discussing who had received their lunch and who still needed assistance and for their lunch to be provided. These conversations included peoples' names and were not person centred. Staff referred to whether people had "been done" or still "needed to be done". We observed one person being supported by a staff member to eat their lunch. The staff member left the dining room and the person managed to independently eat a few mouthfuls. A different staff member then walked past and assisted the person with a couple more mouthfuls. Several staff were assisting people with their meals by standing next to them while people were sat at the table. This was not a person centred approach or respectful of people's dignity. Staff were aware that we were observing which demonstrated that staff were not aware that their use of language or approach was not respectful. We observed some of the lunchtime on our second day and saw that interactions were more respectful with staff sat next to people assisting with their meals. The registered manager had not been working on our first day of inspection and told us that staff would not normally act in this way and they would address this with staff and ensure that use of language and approach was discussed and understood.

People and relatives told us that staff were kind and friendly. One relative said "they're ever so friendly and we've got to know them". A person told us that they got on well with staff and that they were offered choices and another person told us about a member of staff they felt was "brilliant".

Staff communicated with each other to ensure that people received joined up, consistent care. One person had expressed a preference to be called by a different name. This was reflected in the person's care plan and we observed staff calling the person by their preferred name during our inspection. We saw housekeeping staff communicating to care staff about an area which required urgent cleaning and confirming that they were on their way to address this. Staff used handovers to keep up to date about peoples' changing needs and wishes and verbally updated each other during shifts about who needed support and ensured that they worked together in pairs to support people if they required two to be assisted safely.

Staff understood people's preferences and offered them choices in ways which were meaningful for them. One staff member explained how they sought consent to support someone with personal care. They told us they "sit with somebody and give a full explanation….show them things" to enable them to make choices visually where needed. Another staff member explained that they held up clothing choices for one person to enable them to make decisions about what they wore. One person chose to have an alcoholic drink and staff had worked with the person and their GP to agree a plan to provide this for the person at times which would not interfere with their prescribed medicines. This worked well and the person was happy with the plan that was in place and was provided with their drinks when they asked for this during our inspection.

Staff were respectful of people's personal space and bedrooms. We saw that signs were in place to use when people were being supported with intimate care and that staff knocked before entering people's rooms. One person told us that staff were respectful of their privacy and explained "If I want to be left in peace, they

(staff) don't bother me". Another person told us "they(staff) respect my space…always knock on my door". A member of staff told us that they "always shut the door when assisting someone and always knock before entering".

Visitors were welcomed at the home and told us that they could visit whenever they chose. One visitor explained "I can come whenever I want and I'm always offered drinks". Another visitor told us that they felt welcomed and that staff were helpful and friendly when they came in.

Good

Is the service responsive?

Our findings

People had personalised care plans in place which included details about their histories, likes, dislikes and preferences. Care plans also included details about things that could worry or upset people and people who were important to the person. Information about people's religious or cultural beliefs were included and respected. A professional explained that the religious beliefs of a person they visited were very important to them and the home supported the person with this by arranging regular visits from a local vicar. Where people were unable to tell staff about things which were important to them, this information was gathered from relatives and close friends of people. For example, one person's file included information about 'what makes your relative happy'. Another person had been asked about whether they wished to attend church and had declined this but enjoyed the visits from the vicar instead.

Care plans were responsive to people's changing needs. For example, one person had become upset on an increasingly frequent basis. Staff had noticed this change in the person's presentation and involved external professionals. Their care plan reflected these changes and gave details about what advice had been sought and what actions were planned to support the person. Reviews included people and those important to them. One relative explained "I've been to two or three meetings and I'm asking how things are going". Another explained "every so often we have a review, two or three times a year…they'll (staff) always let me know how (name) is". A relative explained that when their loved one was unwell, staff contacted them and drove to collect them to visit their loved one which they had greatly appreciated.

People were supported to engage with different activities and had one to one time with staff. Activities and social opportunities for people were generally provided by staff on an informal basis day to day, but there were also some planned activities on a regular basis which people were able to engage with. The registered manager explained that they took photographs of people engaged in activities to capture this as they could also be looked at by people to prompt conversations and also been seen by those important to people. We saw that photographs included people enjoying a foot soak and foot massage, jigsaw puzzles, easter crafts and painting. A professional told us that staff "often take people out" into the local community and arranged events through the year to which people's relatives and those important to them were invited.

The service met the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Some people at the service had a sensory loss and staff were mindful of this and engaged in ways which enabled people to understand what they were communicating. We saw that the service had considered and discussed a person's communication needs with their relative and an involved professional to determine whether there were further communication options which could be appropriate.

People and relatives told us that they would be confident to raise any concerns or complaints if they needed to. A relative explained that they would approach the registered manager if they had any issues. We saw that where complaints had been received, these had been acknowledged, investigated and responded to.

People were supported to have end of life care which was respectful of their wishes and preferences. Where people had medical decisions in place, these were recorded. Care plans reflected that people's wishes were discussed and the registered manager explained that speaking with people about end of life care was about "finding the right words at the right moment". They gave an example about one person and discussions they had held with them and their family about their fears and wishes for a good death and about whether they wanted medical intervention.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems did not consistently provide effective oversight of the service delivery. Some audits at the service were in place and were effective in identifying gaps, trends and driving improvements. For example, audits of accidents and incidents and medicines. We saw that where an audit of medicines had identified that additional guidance was needed for medicines prescribed 'as required' , an action had been set for this work to be undertaken and had been completed at the time of inspection.

However, other areas did not have effective systems in place which meant that the registered manager was not able to monitor or improve services. Examples included that there was no system in place to monitor whether DoLS authorisations had been applied for, when these were due to expire or whether they had conditions attached. Staff had access to training but there were no systems to guide staff about what training they should complete or monitor whether this had been completed. Although the registered manager was available and visible for staff, they had not identified the cultural acceptance by staff of language and interactions which were not always respectful. The registered manager told us that they would work with the provider to review and ensure that systems were effective and provided complete oversight of the service.

The registered manager told us that they received support from the provider and they were working on a range of areas for improvements at the time of inspection. For example, policies had been found to be out of date and not always in line with current best practice. The provider and registered manager were in the process of planning and implementing a new range of updated policies to cover all areas of the service provided for people. Staff also told us that the provider visited the home regularly and spoke with staff as part of each visit. In order to provide additional oversight, the provider and registered manager were also in the process of considering a deputy manager role to enable some delegation of work and strengthen the management structure.

Fairfield House promoted equality and inclusion within its workforce. The registered manager gave examples of how they had supported staff to ensure that their rights were upheld and that they were treated equally and protected from discrimination.

Staff understood their roles and responsibilities and told us that the registered manager was the registered manager told us "I couldn't ask for a better group" of staff. One staff member explained that the registered manager was generally available and that staff were able to contact them at home if needed. One person told us that they thought the service was well run and said the registered manager "says it straight down the line". The person and their loved one told us that they were "more than happy" with the support provided. A relative explained that the registered manager supported them as the main carer, as well as their loved one and told us that this helped them.

There were regular meetings of the staff team at different levels to discuss any issues and ensure that changes and plans were effectively communicated. There were also meetings for people and those important to them which a relative confirmed they had been invited to attend. The registered manager

explained that they had previously used surveys to gather feedback but because the home was small, they found that speaking with people and relatives and professionals regularly was more effective. Feedback was able to be given more formally through an online survey site which was advertised in the reception area of the home. The provider of Fairfield House had recently changed and we saw that meetings with staff, people and relatives had been held with the provider and registered manager to discuss the changes in governance and discuss any concerns or queries.

The service worked in partnership with other agencies to ensure that people received joined up care. One person had been unwell and needed to go into hospital. Staff at Fairfield House had worked with the hospital to ensure that they provided relevant information and were able to support the person to return home and follow health advice. The registered manager told us that they spoke with the local authority and clinical commissioning group to seek advice and guidance and discuss any concerns or incidents where this was required.