Care Plus Group (North East Lincolnshire) Limited

Fairways Care Home

Inspection report

Little Coates Road
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Grimsby
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DN34 4NN

Tel: 01472357911

Date of inspection visit:
13 November 2018

Date of publication:
07 January 2019

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?	Good

Summary of findings

Overall summary

This inspection took place on 13 November 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

Fairways Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Fairways Care Home provides residential care to 55 older people in one purpose built building. Some of the people using the service were living with dementia. On the day of our inspection there were 44 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like 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.

This was the first inspection of Fairways Care Home under its current registration.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to reduce these risks. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service. Appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People and family members were complimentary about the standard of care at Fairways Care Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and support plans were written in a person-centred way. Person-centred means ensuring the person is at the centre of any care or support and their individual wishes, needs and choices are considered.

Activities were arranged for people who used the service based on their likes and interests, and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint. The provider had an effective quality assurance process in place. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated, risk assessments were in place and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People's needs were assessed before they began using the service and they were supported with their dietary needs.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect, and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People were involved in their care and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

Care records were up to date, regularly reviewed and person-centred.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

The service had good links with the local community.

Fairways Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 November 2018 and was unannounced. An adult social care inspector, a medicines inspector and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

We spoke with three people who used the service. Some of the people had complex needs which limited their verbal communication. This meant they could not always tell us their views of the service so we carried out observations and spoke with five of their family members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, head of care, deputy manager, two senior care staff, two care staff, an activities coordinator, a maintenance staff member, a hairdresser and a volunteer. We looked at the care records of four people who used the service, 10 medicine administration records and the personnel files for three members of staff.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the 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.

Good

Is the service safe?

Our findings

People told us they felt safe at Fairways Care Home and family members we spoke with told us they thought their relatives were safe.

There were sufficient numbers of staff on duty. Dependency tools were used to ensure staffing levels were appropriate to support people's individual needs. These were regularly reviewed. Two family members told us there weren't enough staff on duty at the weekend. We found staffing levels were the same at the weekend as during the week. We discussed this with the registered manager who told us they were aware of the concerns as they had been raised in a relatives' meeting. They told us they were in the process of recruiting an additional senior staff member to promote better leadership and guidance to the team on a weekend.

Appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and prevents unsuitable people from working with children and vulnerable adults. Copies of application forms were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. Records did not show what proof of identity had been obtained from each member of staff. We discussed this with the registered manager who told us proof of identity such as passports, birth certificates and driving licences were checked by the provider's human resources department.

People were protected from the risk of acquired infections. The home was clean, spacious and suitable for the people who used the service. Infection control audits were carried out. Appropriate personal protective equipment (PPE), hand hygiene gel and liquid soap were in place and available. People and family members we spoke with told us the service was clean and tidy.

Risk assessments were in place for people who used the service and described potential risks and the safeguards in place. Accidents and incidents were recorded and analysed to identify any trends and lessons learned. For example, it had been identified there had been an increase in minor incidents between people in the evening. The registered manager had changed the rotas and arranged for an extra member of staff to be available during shift handover. Positive behaviour risk assessments had been put in place for the people involved. This had resulted in a reduction in the number of incidents.

The provider had a safeguarding policy in place. The registered manager and staff understood their responsibilities with regard to safeguarding and staff received training in the protection of vulnerable adults.

Checks were carried out to ensure people lived in a safe environment. These included health and safety, fire safety, and premises and equipment servicing and checks. Records were up to date. The service had a business continuity plan and up to date Personal Emergency Evacuation Plans (PEEPs) were in place for

people who used the service.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

Checks were carried out to ensure medicines were stored at the correct room temperature. Medicines that required cold storage were stored appropriately and temperature records were maintained in accordance with national guidance. New processes had been identified by the service to reduce medicines waste, which had positive results.

Medicine administration records (MARs) contained photographs of people to reduce the risk of medicines being given to the wrong person. All records clearly stated if the person had any allergies. Records documented people's preferences regarding how they wanted to take their medicines. MARs were accurate and up to date. Handwritten MARs were signed by two members of staff to confirm dosage instructions had been transcribed accurately.

Written guidance was in place to enable staff to safely administer medicines which were prescribed to be given only as and when people required them, known as 'when required' or 'PRN' medicines. Risk assessments were in place for people who were able to manage their own medicines. These assessed the risk and described the actions to be carried out.

Instructions for medicines that should be given at specific times were written on the MARs and additional reminders were used. For example, two people were prescribed a medicine to treat Parkinson's disease to be taken at six hourly intervals. Posters were displayed in the treatment room to remind staff when the next dose was due.

One person was prescribed a powder to thicken fluids to help with swallowing problems. However, there were no records to indicate when the thickener had been used. This was discussed with a senior staff member and new documentation was introduced to record the use of thickeners during the inspection.

Regular medicines audits were carried out. Staff received training in the administration of medicines, including topical medicines or creams, and their competencies were assessed regularly to make sure they had the necessary skills. People and family members told us medicines were administered on time and people were encouraged to take them.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. One person, when asked if staff supported them in a way they preferred, told us, "Always, I've never had a problem." A family member told us, "They [staff] do listen to me, I have a meeting in a couple of months to update [relative]'s care plan." Another family member told us, "The care is very good." Another family member told us, "They [staff] always explain what they are doing."

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff responsible for carrying out supervisions were provided with the opportunity to attend a bespoke leadership course, developed with a local university. Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely.

New staff completed an induction to the service. The registered manager showed us a copy of the training matrix. Where there were gaps, the training was planned and booked. The registered manager told us all staff had been enrolled on the Care Certificate as part of their professional development. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. A new 'advanced care assistant' role had been introduced to support care staff who wanted to achieve promotion.

People's needs were assessed before they started using the service and continually evaluated to develop support plans.

People were supported with their dietary needs. Nutrition support plans were in place and described the support people required in this area. People who had been identified as being at risk of choking, malnutrition or dehydration had appropriate risk assessments in place. Advice had been sought from relevant healthcare professionals such as dietitians and speech and language therapists (SALT), and their recommendations were recorded. Kitchen notification forms had been completed for each person that recorded their likes, dislikes, dietary needs, allergies and when the preferred to have their main meal.

A drinks and snacks trolley service was available in the morning and afternoon. The service operated 'protected mealtimes' when visitors were not allowed unless it had been previously agreed. We observed lunch and found it to be a pleasant experience. The food looked appetising and people who required support were assisted by staff or family members. A family member told us, "The food's better now, plenty of it and you get a choice on the day." Another family member told us, "I'm told [relative] eats well and has a choice from two that are shown to her." One person and one family member told us staff took the food away from people too quickly and people weren't encouraged to eat it first. The registered manager told us, "We do make an emphasis on supporting residents who need support with meals." They showed us examples of picture meal cards they were introducing to the home and told us they would introduce dining audits to their audit planner.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. DoLS had been appropriately applied for, mental capacity assessments had been carried out and decisions made in people's best interests were clearly recorded. Records included details of any lasting powers of attorney or advance decisions the person had made.

Consent forms were in place, which included care and treatment, sharing information, having the person's name on their bedroom door, risk management, medication and photography. Some of the records had not been signed by the person or their family members. The deputy manager explained these records had been recently reviewed. They showed us a list of family members to who they needed to discuss consent forms with when they next visited the home.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records were up to date and showed the person and their family members had been involved in the decision making process.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, community nursing teams, occupational therapists, dietitians and SALT. A family member told us that when their relative needed medical help it was arranged very promptly and staff telephoned them to let them know. Oral health assessments were carried out, and the provider was working with dental professionals to improve people's mouth and dental care.

The service had 'discharge to assess' beds at the home. Discharge to assess is about supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. People could then be assessed for their longer-term needs in the right place. The service also had two bedrooms reserved with social care commissioners for respite care.

Some of the people who used the service were living with dementia. The home was suitably designed for people to be able to orientate around the home safely. People's bedroom doors, toilets and bathrooms were clearly identifiable. Handrails were painted a different colour to the walls to make them easier to see. Bedroom doors included the person's name, room number and memory boxes for those that wanted them. Two people's rooms were numbered differently. The service had changed the numbers on the doors to numbers they recognised to help them identify their rooms. The registered manager told us they were consulting with people and family members about future changes to the décor and signage.

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Fairways Care Home. People who used the service told us staff were "caring" and "lovely". A family member told us, "They do generally care and they do try to promote [relative]'s independence." Another family member told us, "Dignity is well respected." Another family member told us, "On the back of [relative]'s door they have a framed poster of what [relative] likes and how to encourage her."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and they interacted with people at every opportunity. Examples of person-centred care included a person had been provided with their own linen trolley that they could wheel around and feel part of the running of the home. Another person wanted a pet so the service had arranged for a budgerigar in a cage to be placed in their bedroom.

Our observations confirmed staff treated people with dignity and respect. We observed staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. The service had three dignity champions. These were two members of staff and a volunteer, who attended local forums and updated the wider staff team on any new initiatives.

Staff supported people to be independent and people were encouraged to care for themselves where possible. Care records described what people could do for themselves and what they required support with. For example, "I am able to dress myself if given the time and encouragement", "I can wash my own hands, face and upper body with prompts". "Staff to hand items to [name] to be able to wash as much as possible independently" and "I am able to undress with verbal prompts. I am able to put nightwear on with verbal prompts."

People's preferences and choices were clearly documented in their care records. Communication support plans were in place that described how people were given information in a way they could understand and the level of support they required with their communication needs. For example, one person could engage in verbal conversation but may require words to be repeated. Staff were to ensure they spoke slowly and were facing the person when communicating with them.

People were supported with their spiritual needs. The service regularly ran a church service that anyone could join in. One of the people who used the service had a spiritual leader that visited on a weekly basis.

Records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Information on advocacy services was made available to people who used the service and some people were using advocates to support them with making decisions. Advocates help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights

and responsibilities.

Good

Is the service responsive?

Our findings

Care records were regularly reviewed and evaluated, and were person-centred. Person-centred means the person was at the centre of any care or support plans and their individual wishes, needs and choices were considered. Records included important information about the person, such as next of kin, contact details for their GP and other relevant healthcare professionals, and details of their personal background, family and friends, and interests. We saw these had been written in consultation with the person who used the service and their family members.

Support plans were in place and included personal care, oral health, night care, independent living skills, emotional wellbeing, skin integrity, nutrition, continence, moving and handling, and communication. These described what the desired outcome of the support plan was, what the person could do for themselves, what they required support with and any other important information. For example, one person was identified as being at risk of pressure damage and had a skin integrity support plan in place. This described the action staff were to take to reduce the risk of pressure damage. A pressure damage prevention risk assessment was in place and guidance had been obtained from the community nursing team. Records were up to date and had been regularly reviewed.

People were supported with end of life care needs. The registered manager told us two care coordinators from the service went to quarterly meetings at the local hospice. The service also had links with local Macmillan and end of life teams. Any learning and good practice from these meetings was fed back to the staff team. The registered manager told us, "It's not just about the person, it's about supporting the families."

Daily records were completed for each person and included diet and nutrition, personal care carried out, visual checks, and activities the person had been involved in. Care co-ordinators ensured that any changes to people's needs were cascaded to the wider staff team, including kitchen and domestic staff.

People were protected from social isolation. The service employed two activities coordinators, who were supported by a volunteer and another person on an employment scheme. Activities taking place at the home during the week we visited included; church worship, quizzes, armchair exercises, biscuit baking, paper decorations, peg dolls and knitting. We observed a quiz taking place in the main lounge and saw 21 people taking part, all were engaged and enjoying themselves. People who did not want to take part in activities had the option of sitting in a smaller quieter lounge, where they could watch television or engage in individual activities. People were also supported to access external activities such as trips to the garden centre and meals out. The service was a member of the national activity providers association (NAPA). The registered manager told us they were focussing on "more quality, person-centred activities" and were working with families to identify what people liked and didn't like.

The provider had an effective complaints policy and procedure in place. The complaints policy was on display in the home, and people and family members we spoke with were aware of how to make a complaint. Complaints records we viewed included details of the complaint, investigation and outcome.

People and family members were generally very complimentary about the service and knew how to make a complaint. The service was in the process of drafting an easy to read complaints procedure that supported the accessible information standard.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since November 2017. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months.

The registered manager, deputy manager and head of care told us about the changes they had made to the home since it had been purchased by the provider. They told us they had made the home "safe" by focussing on the premises, furniture and equipment that had been required. This included the purchase of new moving and handling equipment following inspections of the old equipment found them to be unsafe. We viewed the new equipment, which was stored and maintained in a designated equipment room.

The registered manager told us future projects included developing the main lounge, turning a cinema/meeting room into a sensory room, working with people and families to transform the inner courtyard area into a sensory garden, and developing equipment, in consultation with the maintenance staff, to help people who don't have very good mobility or dexterity to engage in activities and games. They told us the service could accommodate two people with bariatric care needs, and plans were in place to improve areas of the home to promote their social inclusion.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had good links with the local community and volunteer groups. People visited a local hotel for afternoon teas. Local nursery and primary schools visited the service such as at Easter and Christmas. The service held fayres, which were popular with the local community.

The service had a positive culture that was person-centred and inclusive. A family member told us, "It's generally a good atmosphere here, seems well managed." Another family member told us, "The atmosphere is good, well my relative's always smiling so that tells me she's well settled". Two family members told us the service wasn't as welcoming or person-centred as it used to be. This was not evidenced during our visit or from feedback we received from other people and family members.

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. Staff were consulted and kept up to date with information about the home and the provider. Regular staff meetings took place, including meetings for senior staff, night staff, kitchen staff, domestic staff and activities staff. Additional support was provided to staff via welfare risk assessments, and access to occupational health and confidential care services.

The provider had a robust quality assurance process in place, which included seeking people's views about the quality of the service. Regular audits were carried out and included accidents and incidents, care

records, staff supervisions. complaints, health and safety, kitchen, housekeeping, maintenance, medicines, staff files, record keeping, residents' finances, training, activities and infection control. The registered manager maintained an audit planner to ensure audits were carried out when required. Records were up to date. The registered manager told us they and the deputy manager often worked alongside members of staff to promote good practice and check the quality of care being provided.

The provider's quality and performance team made unannounced visits to the service to carry out audits and included a mock CQC inspection. A quarterly performance report was carried out and any actions from this, and other audits, were recorded on a coordinated action plan.

People and family members were consulted about the service. Residents' and relatives' meetings took place every two months. The most recent meeting included discussions and updates on the quality of care, the environment, meals, activities, dementia awareness, visiting hours, and dignity and respect.

A survey called 'Outcome star' was carried out to gather the views of people new to the service or those leaving after respite or short stays at the home. Quarterly surveys took place to gather feedback from people and family members. The results of the most recent survey showed that 100% of people surveyed said the service provided high quality care, they were involved in decisions, they were treated with empathy, dignity and respect, staff were adequately trained and experienced, communication was good, and they would recommend the service. Any issues raised in the survey were actioned and fed back to people and family members.