Farrington Care Homes Limited

The Fairways

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
The Fairways is a care home providing personal care and accommodation to 19 people at the time of the inspection. The service can support up to 20 people and is registered to provide care to older people and people living with dementia. The home is a converted house and accommodates people across three floors. The Fairways is part of Farrington Care Homes Limited, a private company which has other care homes across England.

People's experience of using this service and what we found
The provider did not always identify risks to people and others and did not take adequate measures to minimise the risk of harm to people. Although environmental concerns found at the last inspection had been addressed, we identified further concerns which required urgent attention.

Some people's care plans and risk assessments did not address all risks to them and lacked guidance for staff about mitigating the identified risks. In some case the risk assessments had not been updated in a timely manner. Therefore, they did not reflect people's current circumstances and lacked measures to keep people safe.

We checked the provider's infection control processes and found, whilst there were protocols and procedures, further action was needed to ensure that the risk of the spread of infection was being managed robustly.

The registered manager assessed people's mental capacity to make a range of decisions. Whilst most of these assessments were undertaken in an appropriate manner, one person's assessment was not completed in line with the Mental Capacity Act 2005. The person's records indicated they had not always supported this person's choices when they had been assessed as having capacity to make that choice.

The registered manager had completed audits and checks but they had not identified all the concerns found at inspection. The provider not addressed some areas of the home that required to be made good in a timely manner which could have left some areas of the environment unsafe.

The registered manager sent us an initial action plan following our inspection to tell us that they had immediately addressed some of the concerns found at the inspection and how they planned to address others.

During the inspection we found the provider had made improvements in the safe administration and storage of medicines and were no longer in breach of this section of Regulation 12.

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

Rating at last inspection
The last rating for this service was requires improvement when inspected 24 October 2019 (Published 17 December 2019)

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. In addition, we also looked at whether the provider had made improvements in relation to other breaches of regulations that we identified at the same inspection. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

Enforcement
At the previous inspection the service was in breach of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a Warning Notice on the provider for the breach of Regulation 17 and requirement notices for the breaches of Regulations 11 and 12.

At this inspection we found that the provider had not fully met the requirements of the Warning Notice and remained in breach of all three of the regulations and were now also in breach of Regulation 9 (Person centred care).

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Fairways Care Home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. We will work alongside the provider and local authority to monitor progress. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

The Fairways

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on actions the provider had taken to address concerns named in a Warning Notice served at the last inspection. We will assess all of the key questions at the next comprehensive inspection of the service.
As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

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

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection, including information

from the local authority. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff including the registered manager, deputy manager, care worker and maintenance worker. We reviewed a range of records. This included four people's care records and eight medicines administration records. A variety of records relating to the management of the service, including policies and procedures were reviewed. We undertook a partial inspection of the premises.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to check whether improvements have been made by the provider to meet previous breaches of regulations. We will assess all of the key questions at the next comprehensive inspection of the service.

During inspection in October 2019, we identified risks were not always managed in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

• Previous concerns about the garden area identified at our last inspection in October 2019 had been addressed. However, during this inspection, we found a long section of the garden fence was being propped up as it needed repair. Some items that has been identified for disposal were used to prop it up at one end. This included a bedframe and wooden pole with a metal top. This was not safe as it was not a secure way to keep the fence up and there was a risk it might fall on someone causing them harm.
•There was a hole in the ceiling of the laundry room which was in an out-building, and this meant water could leak into the room which contained electrical equipment. This had not been repaired in a timely manner. We spoke with the registered manager who told us staff covered the roof with a tarpaulin when it rained. This was a temporary solution and the roof still required repair.
•Two fire exits were accessed on the first and second floor through two people's bedrooms. We noted there was a lock on the inside of the bedroom door so the person who lived in the room could (quite rightly) lock their door if they wished. This meant other people, staff or visitors might not be able to go into those bedrooms if the doors were locked, to access the fire escape stairway in the event of an emergency. The provider had not considered this risk in their written fire risk assessment and there was therefore a possibility that there was a delay if people were trying to leave the home in an emergency.
•In addition to the environmental hazards, we found two people's care plans and associated risk assessments were not up to date. The provider had not ensured all risks to the individuals were identified and guidance was not always provided for staff to minimise the risks and keep people and themselves safe. For example, one person's risk assessments did not reference or describe the presentation of their epilepsy and there was no guidance for staff about supporting the person in the event of a seizure.
•A second risk assessment stated a person was at low risk of falls. This had not been reviewed and consideration had not been given to recent falls. Records showed the person had four falls since mid-July 2020 which indicated they might have been at a higher risk of falls and their risk assessment needed to be reviewed to minimise the risk of falls. Some safety measures had been implemented but their care plan did

not state there was a sensor mat beside their bed to alert staff should they leave their bed and be at risk of falling. There was no checking or recording system to monitor the sensor mat use or effectiveness.

We found that systems were either not in place or robust enough to demonstrate safety was effectively managed.
This was a continuing breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
•The provider did not always put in place robust protocols to prevent safeguarding and incidents reoccurring.
•A safeguarding incident occurred in June 2020. This was because checks in the home had not been robust enough and a person had received a clinical intervention from a visiting healthcare professional that was meant for another individual not residing in the home. We asked what steps had been taken to ensure this situation would not reoccur again. The registered manager told us they had spoken with the staff and told them they must always check the names of people the health care professionals have come to visit. However, there were no records to show that current visiting arrangements were reviewed, and that more permanent and robust arrangements were introduced to prevent a similar incident from happening again. For example, there was not a protocol for existing staff or new staff for guidance or reference about how to deal with visiting health and social care professionals to the home. Therefore, we could not be assured all staff would learn from this mistake to help prevent a similar incident from happening again.
•A protection plan following another safeguarding investigation, in December 2019 for one person stated, "In circumstance that [person] is allocated to a male care staff, a female chaperone is to be provided." However, the protection plan was not referenced in the person's care plan which still stated, "[Person] has no preference as to male or female to supervise them with a shower." There was a concern because it did not appear that learning had taken place following this safeguarding investigation to prevent reoccurrence.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed.
This was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Whilst the provider had taken measures to prevent the spread of infection there were some areas which required improvement.
•We found the laundry room which was situated outside the main building had not been cleaned to a good standard. The room required general repair and both washing machines needed to be cleaned. Because the washing machines and laundry room were not clean there was a risk clean laundry could become contaminated.
•Whilst we observed staff remained socially distanced whenever possible most people in the lounge were sitting close together. The registered manager explained people had become distressed when they could not sit next to each other. They had removed two armchairs to make a little more space. However, not enough consideration had been given to help socially distance people for example, by using side tables to create a space between chairs.
•There were PPE stations on each floor, but we noted they were not all well stocked. The first floor PPE station contained no gloves available for staff use which meant they would have had to move to other areas to look for gloves if they needed these.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Notwithstanding the above. The main house was clean and extra cleaning regimes had been implemented. The registered manager was following government guidance and supporting new service users and those returning from hospital to self- isolate for the required length of time before mixing with other people using the service.
•Staff had completed infection control training and during inspection we observed staff wearing personal protective equipment (PPE) at all times. There was a, "No touch" basin for effective handwashing and hand sanitizer available for staff use in the home. The registered manager had stopped staff travelling between care homes to limit the spread of infection.

Using medicines safely
At the last inspection in October 2019, we identified medicines were not always managed in a safe way. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in the administration and storage of medicines and was no longer in breach of this section of regulation 12.

● At our previous inspection we had found medicine administration records, (MARs) were not recorded accurately. At this inspection MARs reviewed were completed without gaps or errors. Staff had signed records after all administrations and the amount of each medicine had been tallied and recorded. When we counted a sample of medicines, the amounts were correct and as recorded on the MARs.
● At our last inspection as and when needed medicine guidance for staff was not signed by the prescribing officer. At this inspection this had been addressed. There were protocols to support staff to administer medicines consistently and as prescribed.
●We found medicines, including prescribed ointments were stored safely. One person who administered their own medicines was provided with a lockable cabinet and their medicines were stored securely in the cabinet.
●The registered manager had checked and audited the medicines to ensure staff remained competent and administered medicines in a safe manner.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

During inspection in October 2019, we identified consent was not always managed in line with the MCA 2005. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 11.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA. 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.

- The registered manager assessed people's mental capacity to make a range of decisions. Whilst most of these assessments were undertaken in an appropriate manner, one person's consent was not sought and respected in line with the Mental Capacity Act 2005.
- An incident form showed that following a fall in July 2020, staff recorded they advised the person to keep a sensor mat in situ. However, the person who had been assessed as having capacity did not consent to the use of the mat.
- In another incident form later in the same month staff described the same person fell because they tried to jump over the sensor mat. The person asked for the mat to be removed following this fall as they did not like to step on it and was avoiding it. However, the mat was not removed despite the person having been assessed as able to decide about the mat being in their bedroom. This meant the person's rights to make

decisions about their care was not being respected and alternative ways to manage the risk of falls had not been explored with the person.

The evidence shows that systems were either not in place or robust enough to demonstrate people's safety was effectively managed in line with the MCA principles. This placed people at risk of harm. This was a continued breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- During our inspection visit we noted occasions when people should have been supported to see a health care professional because of their mental health and behaviour or because of symptoms of physical ill health.
- Examples included one person who has recently expressed self-harming thoughts. This was not flagged as a concern to the mental health team. After we had brought it to the registered manager's attention, they raised this concern with the team. The person's care plan had not been updated to reflect this change in needs for staff to manage this person's changing mental health needs.
- One person received as and when needed Lorazepam, a psychotropic drug. The use of this drug was almost every night as their behaviour became more unsettled during the night time. Therefore, as a matter of good practice a review should have been requested from the relevant health professional to ascertain if the continued use of the medicine was safe and necessary.
- Another person was given as and when needed medicines for toothache in September 2020 but a referral to the dentist had not been made. No dentist visits had been arranged for anyone in the home since October 2019. Whilst we understood the COVID 19 pandemic had delayed some routine treatment, this person was showing symptoms of toothache and should have been supported to see a dentist.
- People's health information was not always current. One person's doctor letter dated April 2020 stated they had a diagnosis of alcohol related dementia, but their care plans and risk assessment stated no dementia diagnosis had been given. There was a concern therefore staff would not understand the person might have dementia care needs and ensured they had appropriate care plans to support the person with these needs.
- We found that records about monitoring people's health conditions were at times inconsistent. One person presented with behaviour which challenged the service. Monitoring charts for this person's behaviour were hourly and these had not been completed consistently. For example, in August 2020 15 days of hourly monitoring for this person were not recorded. Their behavioural guidelines were brief stating to occupy and distract them but contained no details or ideas as to what worked well. This meant adequate monitoring of the person's conditions was not being carried out to support the person with their medical condition so appropriate action could be taken to ensure they receive the optimal care and support.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Notwithstanding the above. The registered manager had worked closely with the community care home matron on an almost daily basis throughout the pandemic to keep people safe from harm. They had put in practice measures as advised. For example, staff had checked people for COVID 19 symptoms such as loss of appetite, and coughs. They had taken and recorded twice daily people's temperatures and taken appropriate action when any symptoms presented. District nurses provided nursing care to people living in

the home and liaised with the staff and registered manager appropriately to ensure people received safe and effective care.

Inspected but not rated

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to check specific concerns from the Warning Notice served following our inspection in October 2019 for a continued breach of regulation 17. We will assess all of the key questions at the next comprehensive inspection of the service.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we found, gaps in quality assurance checks and audits. This contributed to a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

•Despite the provider carrying out care plan audits, we found people's care plans and associated risk assessments lacked important information or were inconsistent. The provider had not ensured all risks to people were identified and had not provided clear guidance to staff to mitigate the identified risks. Care plans and risk assessments had not been updated in a timely manner.
•The provider's systems to manage records were not always effective because they had not ensured staff were consistent when recording people's health needs. This meant information in care records about monitoring people's conditions were not consistent to enable health professional's make informed clinical decisions about the person.
• The arrangements to manage risks to people, staff and others were also not effective. The registered manager had completed a generic staff risk assessment, but they had not completed individual staff risk assessments for COVID 19. This meant risks to individual staff associated with risk factors, such as being from the Black Asian and Ethnic Minorities (BAME) community or being of a certain age or with certain health conditions had not been considered. The registered manager agreed to complete these individual staff assessments following the inspection.
•The provider had a Business Continuity Management Plan dated July 2020, but this did not address the potential impact of Covid 19 on the operation of the business, such as the impact of sustained infection in the home, reduced staffing, low profitability due to lower occupancy, difficulty in accessing daily provision. There was an, "Escalating Measures Coronavirus (COVID 19) Business Continuity Plan," for the period from April to July 2020 but this required updating. For example, there was no mention of routine service user and staff testing. Although this was being undertaken it was not referenced as a way to support infection control.

• Not all hazards had been identified through the health and safety checks so actions could be taken to mitigate the associated risks. This had included, bedroom doors that gave access to the fire escape having a lockable latch, a long area of fencing required to be made safe and a hole in the roof of the laundry room which required urgent repair. The registered manager told us there were plans to repair the fence and the laundry room roof, but this had not been done in a timely manner.
• The last four inspections undertaken in 2017, 2018 and in February and October 2019 were rated as requires improvement. This indicates the provider did not have a robust governance and oversight system to address the quality and safety of the service being provided in the home and to make and sustain improvements in the home to bring the service to at least a good rating.

The above shows that systems were either not in place or robust enough to monitor, assess and improve the quality and safety of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection we found that the registered manager had made improvements to previously identified environmental hazards. This included for instance uneven paving outside the home and unsecured cleaning cupboards and the management of medicines.
• The registered manager told us they were in the process of reviewing paperwork. This included both people's care records and policies and procedures. They had identified some of the issues we raised at inspection. This included the laundry room roof and fence, but this had not been repaired by the provider in a timely manner.

Working in partnership with others
•The registered manager was working in partnership with the community care home matron and district nurses. They liaised with health and social care professionals for the well-being for people using the service.
•To improve the service the provider had commissioned a quality assurance consultant. They had visited the home on the 28 July 2020 to undertake an initial audit visit. The local authority quality assurance team had visited on a monthly basis to check the quality of service provided, offer support to the registered manager and made training available for staff and management.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that service users always received care and treatment that met their needs and preferences and in a person centred way. Regulation 9(1)(2)(3a)(3b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's capacity to consent to their care and treatment was undertaken in line with the MCA 2005 Regulation11(1)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that all risks to the health and safety of service users of receiving care and treatment were appropriately assessed. They had also not done all that is reasonably practicable to mitigate such risks. Regulation12(1)(a)(b)(d)(e)

The enforcement action we took:

We have served warning notices on the provider and the registered manager for failing to provide safe care and treatment to service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that all risks to the health and safety of service users of receiving care and treatment were appropriately assessed. They had also not done all that is reasonably practicable to mitigate such risks. Regulation12(1)(a)(b)(d)(e)

The enforcement action we took:

We have served warning notices on the provider and registered manager for failing to have effective systems to assess, monitor and improve the quality of the service.