Amira Residential Homes Limited

Fairhaven

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 11, 24 August & 8 October 2015 and was unannounced. We last inspected the service on the 1 December 2014 and found that they were not meeting the required standards.

At this inspection we found the service continued to be in breach of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Fairhaven provides accommodation and personal care for up to 21 older people. It does not provide nursing care. At the time of our inspection there were 14 people living at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

The provider did not have appropriate systems in place to ensure there were adequate staffing levels to meet people's needs, and to keep people safe at all times. This meant that people who used the service may not have had their needs met in a timely or safe way.

People's wellbeing was not always supported by staff who met their individual needs and preferences by ensuring people's social needs were met.

Some people told us they felt safe living at Fairhaven. Staff told us they knew how to keep people safe. However risks to some people's safety and well-being were not always managed effectively.

There was an inadequate recruitment process in place which failed to ensure that staff members employed to support people were fit to do so.

There were arrangements in place for the storage, management and disposal of people's medicines. However a serious error was discovered as part of this inspection regarding the stock control for one person's medication. This meant that the system in place to monitor people's medications was ineffective in identifying errors. This error was reported to the local authority safeguarding team following this inspection.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection four applications had been made to the local authority in relation to people who lived at the service and were pending an outcome. Two staff were not fully aware of their role in relation to MCA and DoLS and could not explain how to support people so not to place them at risk of being deprived of their liberty.

There were inadequate systems in place to obtain the views of people who used the service, relatives or other stakeholders.

There was limited information in place to confirm that there were systems in place to monitor and review the quality of services provided and to reduce potential risks to people and drive forward improvement.

People had access to healthcare professionals, including GP's, dentists, chiropodists and opticians.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People who lived in the home were not safe.

Not all staff were aware of the actions to take to ensure that people living in the home were kept safe from harm. This included some staff who had not received safeguarding training.

People were not always supported by sufficient numbers of staff to enable them to receive safe and effective care.

People medicines were not managed effectively.

Is the service effective?

Requires improvement

The service was not effective.

Staff were observed to gain peoples consent prior to assisting them with tasks.

Some staff could not always demonstrate that they had the appropriate skills and knowledge to meet people's needs.

Not all staff were aware of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs).

People were supported to eat and drink sufficient amounts and to maintain good health.

Is the service caring?

Requires improvement

The service was caring.

Staff treated people in a kind and sensitive manner.

People's privacy and dignity was promoted by staff who was gentle in approach, knocked on people`s doors and respected their individuality.

People who lived in the home were not consistently involved in the planning and reviewing of their care.

Is the service responsive?

Requires improvement

The service was not always responsive.

Activities were provided but work was needed to reflect people's individual strengths, hobbies and interests.

People knew how to make complaints and these were responded to appropriately.

Summary of findings

The opportunities for people to feedback on the service requires improvement.

Is the service well-led?

Requires improvement

The service was not well led.

Audits and surveys were not effective in identifying shortfalls in the quality of the service.

The service needs to be more open and transparent

The management team were reviewing ways in which to improve the current service provided.

Fairhaven

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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 11, 24 August & 8 October 2015 and was unannounced. The inspection was carried out by one inspector and an expert by experience.

Before our inspection we looked at the previous inspection records, we also reviewed other information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with the registered manager, seven people who used the service, the manager and five care staff. We also requested feedback from commissioners of the service from the local funding authority.

We observed care and support being provided throughout the three days of our inspection. We also reviewed care records for four people who used the service and three staff recruitment files. We looked at information about recruitment processes, induction, training records, supervisions and appraisals. We also looked at the general maintenance in the homes communal areas, including the kitchen and food storage areas. We sought permission to look in people's bedrooms and bathrooms.

Inadequate

Is the service safe?

Our findings

At the previous inspection in December 2014 we found that the provider had not taken appropriate steps to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff employed to provide care and support for people who lived at the home. At this inspection we found that staffing levels were still inadequate.

People gave us mixed feedback about whether they felt safe in the home. One person told us "I do feel safe, most of the time, except at night, when I have to wait for up to 15 minutes for someone to come and help me." Another person told us that "The staff are kind but always seem to be rushing around and sometimes I need help in the dark and I don't feel safe if I am left on the toilet too long." One person told us that "I feel safe, better than at home where I have had three falls. They look after you here. They are tuned into you, if you are having an off day they keep an eye on you."

We spoke with seven people regarding how the staff responded to their request for support and care. Four people told us that, on occasions they had to wait too long for someone to respond to their call bells. One person told us "Sometimes I have to wait up to ten minutes to get some help to the toilet and by then it's often too late. I find this embarrassing and it upsets me."

We looked at the rotas for July and August 2015. We saw there were four shifts during the month of August where there were only two staff rota'd to cover the hours between 8am and 8pm. We were told that three out of 13 people required two staff to support them with all their personal care needs. This meant that at times, there would be no staff available to support the remaining 13 people, or for staff to take their required breaks.

The lunchtime meal was served at 12.30pm. Some people chose to eat in the dining room, in the lounge or in the privacy of their own bedroom. We were told that four people required assistance with eating their meals. We saw that although two people received support to eat their meal immediately when the food arrived, the two remaining people had to wait until 2p.m to be supported, however we saw that these two people's meals were freshly prepared and were still hot.

We spoke with five staff regarding the training provided in how to keep people safe from abuse. Three people were able to tell us what safeguarding meant in theory, and the types of abuse they would report and who they would report their concerns to, the remaining two staff we spoke with were unable to confirm the theory of safeguarding practices but told us that they would always report any unexplained bruising or concerns to a persons' welfare to the manager.

Although the registered manager understood their responsibilities to keep people safe the records showed that two staff had not received safeguarding training.

The home had procedures in place in the event of an emergency, such as fire and evacuating the home. However two out of five staff were unable to confirm where the fire exits were located and one person told us that they had not received a fire induction before they commenced work at the home. Since the visit took place we have received written evidence that confirmed both staff have now been fully inducted into the home and have completed the new induction programme.

The lack of suitably competent and experienced staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in December 2014 we found that the provider had failed to ensure there was an effective system in place to protect people who used the service from the risks associated with unsafe use and management of medicines. At this inspection we found that the provider had failed to ensure that issues identified at the last inspection had been rectified or improved. This included arrangements for the safe storage, management and disposal of people's medicines.

There was insufficient information available that confirmed all staff had received medicine training. When we checked people's medicines we found that one person had been prescribed a strong painkiller. However the medicine administration record (MAR) stated that the total number of patches remaining should be three but when reconciliation was carried out by the manager 11 patches were counted. The administration of this medication required two staff to sign to confirm the medicine has been given in accordance with the home's medication policy and also protocol for

this medicine. We found that there was only one signature present on 13 May and 1 July 2015. This meant that medicines were not administered safely or effectively and could place people at risk of harm.

People did not always have individual risk assessments in place, and risk had not always been identified or managed appropriately. For example, one person had been assessed by the speech and language therapist [SALT] as being at risk of choking and therefore required their drinks to be thickened. The care plan stated this person should be supervised with eating at all times. However we discovered that this person had been served their lunchtime meal in their bedroom without supervision and without their drinks being thickened. When this concern was raised with the manager we were told that this person does not like a member of staff in their room whilst they are eating. However we saw that no alternative arrangement had been put in place in place which would respect this person's wishes but also keep them safe from harm. This practice meant that the person's health and welfare had been placed at risk. Following our visit the manager has provided written evidence that a further assessment from the speech and language has been taken place with a new risk assessment is in place.

Due to the lack of effective risk management and the management of medicines, this was a continued breach of Regulation 12 of the Health and Social Care Act 2014.

The three recruitment files we looked at showed that the recruitment procedures followed were not robust. We found that essential checks had not been carried out before candidates had started work at the home. We saw that one person had started work three weeks before the necessary checks had been completed. This person's application also had gaps in their employment history for which the registered manager had failed to obtain a satisfactory explanation. The two references on this person's file had been received after the person had commenced work at the home. The application form for another this person was dated and signed in May 2015 however they had commenced work at the home in January 2015.We found that another staff file contained no professional references and provided e-mail addresses as the only form of contact details for this person. We found no evidence that there had been any attempt to verify the information or references provided by this person. The manager accepted that this had been an oversight and since our visit the manager has provided evidence of a new more effective and robust recruitment procedure to ensure these errors do not re-occur.

Due to the lack of safe recruitment practices being carried out this was a continued breach of Regulation 19 of the Health and Social Care Act 2014.

We saw that staff did not wear aprons when they served or assisted people with their lunchtime meal. This meant that there was a risk of infection from staff who had previously assisted people with their personal care and had then proceeded to serve people with their meals.

We looked at the food stocks and storage facilities within the main kitchen. We found that some food that had been opened and left in the fridge was out of date. One jar of curry sauce had been opened on 15 August was still in the fridge on 24 August 2015. However the manufacturer's instructions stated that the sauce must be eaten within two days of opening. We also found that the fruit bowl in the main kitchen contained mouldy bananas and flies had settled on the mouldy apples that remained in the bowl. This had to be pointed out to the chef at the time of the visit. We asked for protective clothing when we entered the kitchen but were given an apron that had several food stains and dried food on it. This was not noticed by the staff and had to be exchanged by the inspector for a clean apron before they entered the kitchen.

Requires improvement

Is the service effective?

Our findings

At the previous inspection in December 2014 we found that the provider had failed to take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. At this inspection we found that people remained at risk from staff that were not inducted or suitably trained to carry out their role effectively.

We were told that new staff received an induction over a period of six weeks which included a period of shadowing an experienced member of staff who knew the people in the home well. However, we saw two new members of staff had commenced work without any induction training and without any shadowing shifts completed. One staff member was unable to tell us the names of the people who lived at the home or where their respective bedrooms were. They told us that "I follow another member of staff and they tell me where to go and what to do." This placed people at risk from staff who had not been inducted or appropriately trained to carry out their role effectively or safely.

We spoke with five staff about the training they had received. Four out of five staff felt they were trained and supported effectively to carry out their role. Records seen showed that one person last received safeguarding training in 2011. Another person's record showed that they had not received fire training, first aid training within the past two years. The records showed that this person last received training in moving and handling in July 2013 and infection control was last provided in April 2012.

The lack of suitably competent and experienced staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training about the MCA 2005 and DoL's and that they understood what it meant. All five staff we spoke with were able to describe how they supported people to make their own decisions as much as possible such as with their personal care and daily choices.

People who who lived in the home told us that consent was sought before care or support was provided. We saw that records of assessments of mental capacity and 'best interests' documentation were in place for people who lacked capacity to make their own decisions. We found that the manager demonstrated a good understanding of when MCA applications were necessary to apply to the local authority. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Fairhaven and were awaiting an outcome. These related to access to the community and people's safety. This meant that people were safeguarded from harm from staff who had been adequately trained and possess the knowledge and skills to ensure that people were appropriately assessed.

People had free access to drinks in the dining room and people told us that the meals were good with just the right amount on the plate.

We saw limited interaction between staff and the people they assisted with their meal. We saw one staff member failed to provide any description about what the person was eating or any attempts to talk with people during their meal.

We spoke with five people about the meals provided at the home. The majority of people told us that they were happy with the choice and standard of meals, although one person did say that they would like to be offered more choice at breakfast. They told us "It always seems to be toast and cereal and I am used to a full cooked breakfast but rarely get asked if I would like it." We looked at the menu for the next four weeks and these demonstrated that the home catered for a variety of cultural needs, with included curries, salt fish and a diverse range of fruit and vegetables.

We saw that although people did not have a formal nutritional risk assessment in place, there was evidence that confirmed that people's weights were recorded and monitored on a monthly basis. We saw that one person had been placed on a fluid chart in order to monitor their daily fluid intake. We saw that these charts had been reconciled after each 24 hour period . We saw that this person had also been referred to the community dietician for further support and advice.

Overall we found that people were referred to healthcare professionals quickly when they became unwell, appointments were made and a record kept within the

Requires improvement

Is the service effective?

person's care plan. Two people we spoke with confirmed that they attended regular GP appointments and were able to receive visits from the optician and chiropodist when required.

Requires improvement

Is the service caring?

Our findings

People told us that the staff were kind and caring but also told us that staff didn't always come when they need help. We were told by one person "I would like staff to have time to just sit and talk to me." Another person said that "When I need a bath the staff do it in a kind way and don't rush me, as I am very slow." Visitors to the home told us that they were happy with the care and that the staff were kind and caring. Another person told us that "I feel I am looked after well, they do everything they can for you but they can't work miracles."

One person who required help in personal care and help with bathing, told us "Staff are very caring and gentle and respect my dignity". They told us that they were "Never embarrassed or compromised. One person was very pleased that they were able to bring their cat with them when they moved into the home.

However during our observations one member of staff entered the sitting room and did not speak to anyone of the eight people sitting in various parts of the room. They did not smile at anyone or make any eye contact. We saw one person who made a gesture with their arms in order to call the staff member over to them. However this was not acknowledged or responded to by the staff member who left the room without any acknowledgement towards the person. We later looked at their care plan and saw that this person rarely spoke. Staff had missed this opportunity to engage with the person.

We saw one person had Afro Caribbean music playing on their television, we saw that this gave the person great pleasure as they happily danced along to this music. This demonstrated that the staff were responsive to this person's musical tastes and enjoyment of dancing. This person was not able to verbally communicate but showed clear enjoyment in their dancing to the music.

Confidentiality was maintained within the home and information held about people's health, support needs and medical histories was kept secure. Information about the complaint procedure was displayed within the main reception of the home.

We spoke with four staff about their knowledge regarding people's preferences and personal histories. Two out of four staff we spoke with told us that had not had chance to find out about this since starting work at the home but they told us they did talk to people about their life experiences and what they used to do prior to living at the care home, when they had chance. The staff said that they always asked people how they would like to be supported with their care. Some people were encouraged and prompted to attend to their personal care needs themselves, so that they maintained some of their independence.

People gave varying opinions with regard to if they had been involved in their care plans. We looked at four care plans during this visit but none had been signed by the person or their representative or had an 'End of life section' within the main care plan. This meant that people may not receive the appropriate care and support in line with their choices and wishes.

Requires improvement

Is the service responsive?

Our findings

People were not always involved in the planning or review of their care. There was no evidence of individualised or personalised information that staff who cared for people living with dementia could use. Although some people's likes and dislikes were recorded, two out of four staff we spoke with were unaware of them. The home used tick sheets to assess people's needs in relation to mobility, continence and nutrition. People's individual needs in relation to their health, mental welfare and conditions were not explored and therefore not documented or available to staff to assist them in delivering care. We could find no reference to preference or choice detailed in this folder or any of the care plans we looked at. We saw a section within the care plans that related to daily routines but these were a list of general tasks required and not any individualised lifestyle choices.

We observed that some staff did not always communicate with people in a way they could understand. They showed no understanding of the needs of a person who showed signs of distress. During our visit we saw one person calling out for help. This person was ignored by staff as they passed their bedroom, on three occasions. We saw that it took a further 7 minutes before a staff member responded to their call for help. We were told that "They were always like that and they just do it for attention." This information was handed on to the manager at the end of the inspection for their attention.

We did not see any meaningful activities provided during our inspection. When we spoke with the manager about this, they told us that many people did not want to participate in activities within the home, but preferred to pursue individual interests outside of the home or to visit their friends and families. However three people we spoke with told us that they were often bored and wanted more opportunities to go out of the home to visit places of interest. One person told us "I feel like a prisoner because I am desperate to get out more but I am told there are not enough staff." Another person told us that they would like to go out and visit a garden centre or take a trip to the shops but had not been offered this opportunity within the past year.

The activity programme had not been updated since 2013 and therefore did not necessarily reflect the changing interests of the people who lived at the home. Throughout our three day visit we observed the television within the main lounge was selected to the same programme that was repeatedly played over and over again. We saw that none of the staff noticed this, offered people the choice to change the channel or offered an alternative activity. The activities primarily offered on a regular basis were bingo and skittles but this was not an activity that was commonly reflected, as an interest, within people's individual care plans. This meant that people were not always provided with a range of activities that reflected their individual interests or hobbies.

This was a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

At this visit we saw no evidence that meetings had been held in order to provide an opportunity for people and their relatives to give feedback and share their experiences about the services provided. We were told that the manager had daily contact with people and therefore discussed any issues or concerns on an informal basis. However there was no evidence that confirmed that issues raised by people, had been formally addressed or responded to. This meant that the manager did not have a system in place that actively encouraged feedback or listened to what people had to say in order to learn and improve upon the services provided.

The home had a complaints policy and procedure in place, as well as a complaints book which appropriately recorded complaints, the action taken and the outcome of the complaints. We spoke with three people who told us that they were unaware of the complaints procedure. One person stated that would speak to their carer or at least the one they get on the best with about anything they were unhappy about."

Requires improvement

Is the service well-led?

Our findings

At the previous inspection we found that the provider had failed to provide and maintain accurate records. At this inspection we found that some care records, training records and medication records remained incomplete. Since the visit the manager has provided written evidence that a comprehensive medication audit has been conducted and a more robust medication system is now in place. Training records have also been updated since the visit took place, which confirmed staff have completed the required training to carry out their role effectively.

At the last inspection we were told that the acting manager resigned in December 2014. At this inspection we were informed that the recently appointed manager had also left the service unexpectedly, in February 2015. We were told that the recruitment of a new manager was actively being sought.

We looked at how the provider monitored the home through auditing and reviewing the quality of service. We saw that although these systems were in place, the manager had not completed any audits that related to medication, care plans or health and safety since January 2015. The manager told us they reviewed all aspects of the service on an informal basis and therefore no records of the audits had been maintained. However we did find evidence that both cleaning and infection control audits had been carried out and were up to date.

We found that although staff had been provided with the training necessary to carry out their role safely, the records that related to this training had not been updated since February 2015.

People's care records when reviewed did not always contain sufficient detail to provide a comprehensive account of a person's needs and care. Care plans did not always contain sufficient information about a person's life history, needs or preferences, and had not always been sufficiently reviewed when required. The care plans we reviewed also did not always reflect people's preferences or choice and some individual risk assessments had not been completed or reviewed. This included people who were at risk of choking. This meant that staff had not maintained an accurate, up to date record of people's care needs.

The people who used the service or their representatives were not included in the development of the service because the manager chose to speak to people informally with regard to concerns or issues they had. This meant that there was no verifiable way of knowing what issues people had discussed and if these had been resolved or actioned.

The stimulation offered did not always meet the changing needs of the people within the home. Two people told us that they were not always assisted to pursue their interests and hobbies.

Medication systems in place failed to identify a serious error with regard to one person's pain relief medications and the manager was unable to clarify or resolve the error at the time of this visit.

The lack of effective leadership and governance and deficiencies in the monitoring and auditing of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The Provider did not ensure that care was provided in a person centred way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to ensure that people were protected from the safe management and administration of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to ensure that there were systems in place to assess, monitor and improve the quality and safety of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider failed to ensure that there were sufficient numbers of staff at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

The provider failed to ensure that a safe and effective recruitment system was in place in order to ensure people who use the service were safeguarded from harm.

This section is primarily information for the provider

Enforcement actions

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