Fairways Residential Home Limited

Fairways

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Fairways is a residential care home providing personal care for up to 24 people. The service provides support to older people and people with dementia. At the time of our inspection there were 19 people using the service. The service is in 1 large, adapted home over 3 floors with a lift, lounge areas, an outdoor seating area, and 2 dining rooms.

People's experience of using this service and what we found
People did not have adequate, complete, and up-to-date person-centred care plans and risk assessments. This meant there was a risk people's individuality, preferences, and risks might not be understood by all staff and people may come to harm.

Fire safety measures, security checks, and emergency planning were not adequate. Management and oversight of fire safety and emergency planning was not consistent and up to date. Security checks did not include all areas. This meant should there have been an emergency, or an area left insecure, people would have been at risk of harm.

Recruitment practices adopted by the home were not robust. The provider did not have a clear system with documented evidence of all requirements and checks. The recruitment policy and procedures did not support safe recruitment. There were no regular checks on recruitment files. This meant it was not always possible to evidence all staff were safe to deliver care to people.

Systems in place were not effective enough to support the safe management and administration of medicines. The provider was changing from paper-based systems to electronic systems, causing duplication of entries and two systems were running at the same time. Time-specific medications were not managed well. Medication audits were not effective. This placed people at risk of harm from unsafe practices in relation to the management of medicines. The systems around the management of controlled drugs were safe.

Processes and systems in place to oversee, assess, and monitor the safety and quality of service provided were not effective. The provider had started a new quality assurance system, this was not embedded. The provider's policies were not current. This meant appropriate actions may not be taken to ensure the service consistently provided safe care and treatment.

People and their relatives felt the service was safe. Relatives told us there were enough staff around who were kind and attentive to people's needs. There was training for staff in keeping people safe and the manager was checking to ensure staff understood the training.

The management of infection prevention and control was good. People in the home, staff and visitors were kept safe from infection following current guidance.

The manager was learning lessons when things went wrong. There were checks on falls where the manager was looking for trends and any themes to make improvements. The manager had an improvement plan of things she was acting on.

The provider had clear vision and values regarding the support they provided. There were regular meetings with the manager and provider. Staff told us they were supported by the manager. People who used the service and their relatives found the manager approachable, and they acted on any concerns quickly. The service was working well in partnership with other healthcare professionals and the local authority.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 3 March 2022) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations. The service is now rated inadequate.

Why we inspected
We carried out an unannounced focused inspection of this service on 1 and 6 June 2023. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance. We undertook this inspection to check they had followed their action plan and to confirm if they now met legal requirements.

This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

We found evidence during this inspection people were at risk of harm regarding our concerns. We have found evidence the provider needs to make improvements. Please see the relevant key questions sections of this full report for the action we have asked the provider to take.

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

Enforcement
We have identified continued breaches in relation to safe care and treatment, good governance, and fit and proper persons employed. Please see the action we have told the provider to take at the end of this report.

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.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

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

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Fairways

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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 team consisted of 2 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Fairways is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Fairways is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 8 months and had submitted an application to register. We are currently assessing this application.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 1 June 2023 and ended on 21 July 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent 2 days on site observing the provision of care. We spoke with 3 people who used the service and 8 family members. We spoke with 7 members of staff including the manager, senior staff, care workers, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 3 people's care plans, 5 staff files, and a variety of records relating to the management of the service including health and safety and quality assurance. We requested documentary evidence to review remotely following the inspection site visit.

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.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure care and treatment was consistently provided in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Care plans were not person-centred, complete, and up to date. Some risks assessments had not been fully completed or were not current. This meant staff did not have a good understanding of the person, their risks, and how to manage them.
- Fire safety measures were not adequate. There was not a safe exit from the rear of the building for people to use. Materials that could catch fire quickly were stored next to the building. Fire safety checks were not embedded. This meant that should people have needed to leave in the case of a fire, the exit might have been inaccessible.
- Emergency plans were not current. There was an emergency plan in place although it had not been reviewed in a timely manner. Personal Emergency Evacuation Plans (PEEPs) had not been reviewed to ensure they were up to date. This meant that should the provider have an emergency people could come to harm.
- Security arrangements were not always checked. The secure outside seating area was left unlocked, although it was meant to be secure. A window was missing a window restrictor. Both were unnoticed by the manager and staff during checks. This meant some areas of the home were not secure.

We found no evidence people had been harmed. Effective systems were not in place to identify and manage risks to people's safety. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider responded immediately and acted during and after the inspection. Fire safety was improved. Work had been performed to reduce risks including updating all PEEPs, installing a new walkway for fire evacuation, and removing combustibles. Emergency plans had been reviewed. The window restrictor had been installed.
- At the last inspection, there was a failure to recognise and report serious incidents, putting people at risk of receiving unsafe care and treatment. The manager had now submitted statutory notifications and reported serious incidents. This meant the appropriate authorities were told when events happened, and

the provider was working in a more transparent way.
● People felt safe and protected from abuse. Relatives told us they felt their relative was safe. A relative told us, "Sufficient staff about and the staff are so kind and patient, always the same regular staff." This meant that while there were risks, the feeling of people and relatives was good regarding safety.

Using medicines safely

At our last inspection the provider had failed to ensure care and treatment was consistently provided in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Medication systems were not safe. The storage area was disorganised. The provider was introducing electronic administration records which meant there were 2 systems working at the same time, both paper and electronic. This meant staff could be easily confused, and things could be missed.
● Medication administration was not always safe. Time-specific medications were not administered correctly. People's medication profiles were not current, including for medications people could request when needed. When requested medications were taken, we did not see a result of the administration recorded to see if the treatment was effective. This meant people were not receiving their medicines effectively to gain the most benefit from their medication.
● Medication checks were not effective. The stocks of people's medication did not match the records. Some medications were not packaged or accounted for, such as over the counter medicines and medicines applied to the body in cream form. The temperature checks of the medication refrigerator showed it had gone beyond requirements but did not show action had been taken. This meant medications could be ineffective when it came time to administer them.
● One person was given their medication covertly. This means the person was not aware they were taking the medicine. There was no current authorisation in place to administer in this way. This meant the appropriate steps had not been taken.

We found no evidence people had been harmed. Effective systems were not in place to manage medicines safely. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately and acted during and after the inspection. Processes were put in place to ensure time-specific medication was administered correctly. The manager contacted the GP and authorisation was provided to administer medication covertly to the 1 person. An urgent referral was made to have this authorised legally by the local authority.
● Controlled drugs were managed well with clear records kept.

Staffing and recruitment

At our last inspection the provider had failed to ensure fit and proper persons employed in a safe way. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Staff recruitment was not safe and consistent. There was not a clear recruitment standard for all documents obtained in recruitment, such as references, and suitability checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Some staff files did not have the DBS number noted to show it had been checked. Full employment histories were not always obtained. This meant the information to ensure staff had been recruited safely could not be checked to ensure they were safe.
● The provider's recruitment policy did not support safe recruitment. It did not have an associated procedure, ensuring an audit trail was kept of recruitment documents and decisions. This meant there was no clear guidance from the provider for the manager and staff to work to and gaps in recruitment records were seen.

We found no evidence people had been harmed. Effective recruitment practices to ensure fit and proper persons employed were not in place. This placed people at risk of harm. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trained in essential courses. The manager had a list of all staff and their training needs and had monitored this to ensure compliance.

Systems and processes to safeguard people from the risk of abuse

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 MCA requires, 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We were not always assured the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● The provider had ensured staff had received training on how to identify and report abuse. This training was tested to check understanding. Staff told us they knew how to report abuse.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The visitor arrangements at the service were in line with current government guidance. Visitors were in the home throughout the inspection. Visitors were questioned about their current health symptoms and PPE was available for visitors to use upon entry.

Learning lessons when things go wrong

● The manager was reviewing falls to check the circumstances to see if lessons could be learned to reduce falls in future.

● The manager found people were not always reading the menu board and this was causing confusion. There were plans in place to photograph and display photos of food choices to help people understand the menu better.

● There was an improvement plan in place for general work and when things went wrong. This documented the needed change and plans for improvement.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure the quality and safety of the service provided; Policies and procedures were not always followed correctly; and the oversight of risk management was not robust. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider did not always understand the principles of good quality assurance.
- The provider did not always manage and respond to risks internally prior to external reviews.
- Quality assurance systems were newly developed and not yet embedded. There were gaps in the performance of this new system. This meant the provider and manager did not have clear information on which to measure the service's quality.
- This is the second consecutive inspection where this has been rated as requires improvement or below.
- There was no registered manager in place at the time of inspection. There was a manager who had applied to be the registered manager, but this had taken some time.
- The provider's policies were out of date. Some policies did not have a date on them. This meant there was no clear standard for the manager and staff to operate to.

We found no evidence people had been harmed. Systems had not been established to ensure good governance, to continuously learn, and improve care. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had submitted statutory notifications for events in the home requiring notifications. This meant the manager had notified relevant organisations and was working transparently. The manager had also reported events to the local authority when required.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people

- Although the provider had clear vision and values the processes were not embedded to support this.

● People told us their care was person-centred and the home was inclusive.
● The provider had regular meetings with the manager to support them in their role and to ensure the manager's performance standards were met, although there were no clear timelines for improvements to be made to drive changes.
● Staff were listened to and encouraged to improve the service. Staff told us the manager listened to them and recent changes had been improving the service for people and staff. The manager was enlisting the support of staff to develop new quality assurance tools and to support more activities for people who live in the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager demonstrated knowledge regarding duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People who use the service and their relatives were able to talk with the manager to be kept up to date with any changes and improvements. Relatives told us the manager was approachable and would act on any issues or comments made. Most relatives told us they would recommend this home.
● The manager worked in partnership with others. Health professionals we contacted told us the service was moving in the right direction from where it was last year. Staff told us the manager listened to them and was supportive.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems had been established to assess, monitor, and mitigate risks to the health, safety, and welfare of people using the service though these were not embedded into practice; staffing and recruitment records did not demonstrate compliance; and people were not supported with safe medication systems. This was in breach of Regulation 12(1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure good governance. Systems had not been established to ensure good governance, to continuously learn, and improve care. This was in breach of Regulation 17(1)(2)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems had not been established to ensure persons employed for the purposes of carrying

on a regulated activity were of good character and recruitment records retained to demonstrate this.

This was in breach of Regulation 19(1)(a)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.