Fairhope Ltd

Fairhope

Inspection report

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Date of inspection visit:
12 March 2018
13 March 2018
16 March 2018

Date of publication:
11 April 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 12, 13 and 16 March 2018 and was announced.

The service is registered to provide personal care to people living in their own homes. At the time of our inspection the service was providing personal care to 24 people.

This service is a domiciliary care agency. It provides personal care to people living in their own apartments in the community. It provides a service to older adults, younger adults, people with dementia, physical disability or sensory impairment. Not everyone using Fairhope receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Fairhope office is situated in Wimborne. It provides support to people living in Bournemouth, Poole and surrounding areas.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of the risks that people faced and understood their role in managing these to ensure people received safe care.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training and support to ensure that they had the necessary skills and knowledge to meet people's needs.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care.

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

People were supported to make choices about all areas of their support and staff understood the principles of mental capacity.

People were supported to have enough to eat and drink. People's preferences for meals were well known and staff offered people choices about what they ate and drank.

Where people had medical decisions in place around their end of life care, these were recorded. Some care plans reflected that end of life wishes and preferences had been discussed. The registered manager told us that they would ensure that people's choices and preferences were consistently discussed and reflected in people's care plans.

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

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

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

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

Staff were confident in their roles and felt supported by the registered manager and office team. Feedback from people and relatives indicated that the manager was approachable, listened and took actions where necessary.

Quality assurance measures were used to highlight whether any changes to policy, processes or improvements in practice were required. The registered manager and provider were working on ensuring that systems were proportionate to the type and size of service and provided consistent oversight.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

Risks people faced were understood and managed by staff.

Appropriate pre-employment checks were carried out for new staff.

Sufficient numbers of staff were deployed to meet people's needs.

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

People received their medicines as prescribed.

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

Is the service effective?

Good

The service was effective.

People were asked to consent to their support and staff understood the principles of the Mental Capacity Act 2005.

Staff received training and supervision to give them the skills they needed to carry out their roles.

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

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

Is the service caring?

Good

The service was caring.

People were supported by staff who were compassionate and kind.

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

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

Is the service responsive?

Good

The service was responsive.

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

People and their relatives were listened to and felt involved in making decisions about their care. Where changes were required, these were acted on and reflected in care plans.

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

Is the service well-led?

Good

The service was well led.

People, relatives and staff spoke positively about the management of the service and told us that they were able to speak with the office when they needed to.

Staff felt supported and were confident and clear about their roles and responsibilities.

Feedback was used to plan actions and make improvements.

Quality assurance measures were used to identify patterns or trends. The registered manager was working with the provider to ensure that systems to provide oversight were proportionate and consistent.

Fairhope

Detailed findings

Background to this inspection

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

The inspection took place on 12, 13 and 16 March 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and able to assist us to arrange home visits.

The inspection was carried out by one inspector on the first day and by two inspectors on the second day. We visited the office location on the first day to see the manager and office staff; and to review care records and policies and procedures. On the second day we visited people in their own homes.

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

We had requested and received a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information during the inspection.

During the inspection we visited seven people who used the service and spoke with three relatives. We also spoke with ten members of staff, the registered manager and nominated individual. We spoke with two professionals who had knowledge of the service.

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

Following our inspection visit, we requested further documentation from the service. This included contact details of relatives who had given consent for us to possibly contact them and feedback survey responses. This information was provided.

Good

Is the service safe?

Our findings

People and relatives told us that staff provided safe care and treatment. One relative explained "they (staff) make people feel very safe and cared for in their own homes". Comments from people included "They(staff) are always cheerful and helpful, they tick all the boxes" and "I feel safe and cared for". We observed staff supporting people safely in their homes. Examples included a staff member reminding a person to keep their arms in when moving through a doorway in a wheelchair, walking with a hand on a person's back to offer reassurance and staff checking that a person was able to manage their medicines independently.

People were protected from the risks of abuse by staff who understood the signs of potential abuse and were confident to report. Staff were able to explain signs which may indicate abuse such as "bruising, if (a person was)tearful which would be out of the normal, lack of food in the home". We saw that safeguarding alerts had been made to the local authority where appropriate and this information has also been sent as required to CQC. The registered manager told us that any outcomes of investigations were shared with staff through supervisions.

Staff understood the risks that people faced and their role in managing these safely. For example, one person was at risk of falls. We observed staff assisting them with patience and reassurance so that they were not rushed and were able to walk with supervision. The person explained that staff understood that their balance was not good and this helped them feel safe. Another person needed assistance to move in bed and was at risk of pressure areas. Staff closely monitored the person's skin and had contacted the District Nurse(DN) the day before we visited because they were concerned that the person's skin had deteriorated. Staff told us that they had been advised by the DN to assist the person to change position at each visit. This was reflected in the persons daily notes. One relative commented "we definitely have confidence that staff respond to risk promptly".

People were supported by sufficient numbers of staff who were recruited with appropriate pre-employment checks in place. People received rota's letting them know which would be visiting them and told us that they were familiar staff who they had go to know and saw regularly. Rotas showed that people had staff who visited regularly and staff told us that they generally visited the same people each week. The registered manager explained that they had sufficient staff but were always recruiting and that new staff were usually recommended through word of mouth or leaflet drops in the local area.

Recruitment files contained references from previous employers, identification checks and application forms. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people.

Staff told us that their visits were well planned, with time to travel between people's homes so that they arrived on time and did not have to rush. One staff member explained "The rotas are worked out well, the routes are well planned". A person explained that staff usually arrived on time and we observed that the office had alerted a person when their visit had been delayed.

People received their medicines and creams as prescribed and these were recorded accurately. We looked at the Medicine Administration Records(MAR) for four people and saw that medicines had been administered and signed for correctly. Where people managed their own medicines, this was recorded and respected. Some people had medicines prescribed to be taken 'as required'. These were recorded in MAR but codes were not always used if people had not needed their medicine. The registered manager was already aware of this and following up with staff to ensure that they were clear about how to record these medicines accurately. Another person had a medicine which required additional checks and we saw that these were in place. Where people had prescribed creams, information included where they were to be applied and with what frequency. These were reflected in people's MAR.

Staff understood their responsibilities to raise concerns or report incidents and these were used to learn and drive improvements. Staff were vigilant about reporting any issues including medications errors or missed visits to the office and these were then followed up and used to identify any learning. For example, where a medication error had been made, staff reported this to the office. A medication incident report form was completed identifying what happened, who was contacted and actions taken as a result to prevent reoccurrence. Incidents and accidents were then reviewed monthly to consider any patterns or trends and take actions where needed.

Staff understood how to protect people from the spread of infection and used appropriate Personal Protective Equipment(PPE) when supporting people. We observed staff using gloves and aprons to assist people and disposing of these safely to protect people from the risks of infections being spread. Regular spot checks and competency checks of staff included monitoring had washing procedures and that staff were wearing PPE appropriately. The service had an infection control policy in place which included processes for staff to follow and were available for staff in the office if needed.

Good

Is the service effective?

Our findings

At our last comprehensive inspection on 30 January, 2 and 8 February 2017 we found there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person did not seek consent from the relevant person when carrying out care and treatment and where people did not have the capacity to consent. At this inspection we found that improvements had been made.

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. We checked whether the service was working within the principles of the MCA.

At this inspection we were told by the registered manager that no-one receiving a service required an assessment of capacity because people were able to make decisions relating to the care and treatment they received. We saw that where people had legal powers in place which provided relatives with the legal power to make decisions on their behalf, these were recorded and copies included in people's care plans. Staff told us how they would consider whether a person was able to make decisions about their care and treatment and what they would do if they were concerned that a person may lack the capacity to make certain decisions. The office team had relevant paperwork to assess capacity and make decisions in people's best interests where required and understood the principles of MCA and their role within the legal framework.

Fairhope completed initial assessments with people to establish whether they would be able to meet their presenting needs. A member of staff told us that they visited people in their own homes to complete pre-assessments wherever possible so that they could see the person in their own environment and understand how they wished to be supported. Where people were in hospital, pre-assessments were sometimes started on the ward before a second follow up visit when the person was discharged home. Pre-assessments included details about people's preferences and risks they faced. They considered whether people had religious or cultural needs which staff needed to be respectful of and formed the basis of the persons ongoing care plan. People and those important to them were involved in these assessments.

Staff received training and development opportunities in areas which were relevant for the people they were supporting. This meant that staff had the necessary skills and knowledge to effectively support people. Staff undertook some training in subjects which Fairhope considered essential. These included fire safety, dementia, nutrition and hydration and first aid. Staff told us that if they identified further development needs they were supported to undertake these. Some staff were involved in obtaining national qualifications in health and social care. The service used a training matrix to ensure that staff were up to date with training and where topics needed to be refreshed, these were identified and followed up with staff. One person told us about a medical condition and explained how it affected them. They told us "staff are aware of what it is and how it affects me".

Staff received an induction before they started supporting people in the community. We saw that a national tool was used to ensure that staff learned about the different standards of care and treatment. New staff shadowed more experienced staff members and this was recorded and competence considered before staff worked in the community alone. Where more shadowing or learning was required before staff worked alone, this was provided.

People were supported to have enough to eat and drink if they required assistance with this. One person told us "I choose what I want for meals and staff heat something up for lunch for me". We observed staff offering people choices about what they wanted to eat and encouraging people to drink and eat when they visited. People had drinks left for them to try to encourage them to drink between staff visits and staff completed food and fluid charts to monitor whether people were eating and drinking enough and highlight any concerns. We observed staff taking the time to encourage a person to eat their breakfast. The person felt their bowl and was worried that because the bowl felt hot, the breakfast was too hot. Staff suggested putting their breakfast into a cold bowl. This change was effective for this person and meant that because the bowl felt cold, they were happy to eat their breakfast. Staff had received food hygiene training and wore PPE when preparing meals and drinks for people.

People's care plans included 'grab' sheets which were designed for emergency services to provide essential information about people if they required admission to hospital. Details included people's next of kin, GP, any allergies and relevant medical information. This ensured that relevant information was shared between services to ensure the person continued to receive effective support and that their individual needs were known.

People were supported to access health professional support in a timely manner. We observed that one person was not well at the time of a visit. Staff quickly identified that the person was not presenting in their normal way and explained that this was out of the ordinary. They suspected an underlying health cause and requested an urgent GP visit the same day. Another person was visited by district nurses while we were with them. Their visit had been triggered by Fairhope staff who had identified a potential breakdown in the person's skin and had followed this up with district nurses the same day. A staff member explained "we have good communication with other health professionals".

Good

Is the service caring?

Our findings

People were supported by staff who were kind and compassionate in their approach and showed warmth and affection. Interactions were friendly and tactile with staff offering people verbal and physical reassurance and encouragement. We heard laughter and chatter between people and staff who had formed strong relationships because staff regularly visited the same people. One relative explained that their loved one was "always having a laugh and joke (with staff), I can't fault them. They select and employ staff who have that extra caring touch". A person explained "they (staff) make a difference just by coming here".

Staff offered people choices about their care and treatment in ways which were appropriate and enabled people to have control over their support. For example, one person was offered choices about what they wanted to wear and another told staff what breakfast they wanted them to prepare for them. Care plans included details about where people were able to make choices about their support and we observed staff offering choices in the ways described.

Staff sought consent from people before providing any support and explained what they were doing while supporting people so that people were reassured and fully involved in their care and treatment. We observed a member of staff seeking consent from a person to assist them to wash and to move in their bed. The person gave verbal consent to this and staff explained what they were doing as they provided the support to reassure the person.

People's religious and cultural beliefs and individual preferences were recorded and respected. Care plans included whether people had cultural needs which staff needed to be aware and respectful of. This also included whether people had a preference for receiving support from male or female staff. One person was asked confirmed that they were happy to receive support from female staff. This was important because at the time of inspection Fairhope had all female staff. One staff member explained that this was considered at the pre-assessment to ensure that people's needs could be met.

Where people were unwell or in pain or distress, staff responded in a timely and compassionate manner to reassure people and seek external assistance where needed. One person had fallen and staff had found them when they visited. They had stayed with the person, sought emergency assistance and contacted the person's family. A relative told us that they had been contacted when their loved one had fallen and that staff had stayed with their loved one until they arrived. An involved professional explained that staff "come to me and let me know if there are any concerns" about a person.

Staff were respectful of people's homes and privacy. People told us that staff entered their homes in the way they wished, we observed that staff knew how people wanted them to enter their homes and these preferences were reflected in people's care plans. One staff member assisted a person to their bathroom and then provided them with privacy until the person requested they assist them. People told us that staff left their homes neat and tidy and ensured that they were as covered as possible when assisting with intimate care.

People were encouraged to be as independent as possible and care plans included details about what abilities people had and what they were able to do for themselves. We observed that staff encouraged people to manage some of their support themselves and assisted where necessary. For example, one person was trying to stand from their chair with the assistance of a frame. Staff gave verbal encouragement and reassurance but did not rush the person or offer to assist. This meant that the person had the time and encouragement to stand independently which they were able to do.

Good

Is the service responsive?

Our findings

People and those important to them were involved in decisions about their care and treatment. Reviews were planned annually or more frequently if people's needs or circumstances changed. The service was in the process of changing their care planning paperwork and the new care plans included pen profiles for people which gave details about what was important to them and what goals they wanted to achieve.

Care plans reflected people's physical, mental, emotional and social needs and ensured that people were treated equally and as individuals. The registered manager told us that at the time of inspection they did not have anyone from the Lesbian, Gay, Black or Transgender community, but that "it would be the same as completing a care plan for anyone…..we will put together the care plan to suit your individual needs". They went on to explain that staff would accommodate and support people according to their preferences and that they had a focus on equality. Staff received training around equality and diversity and the registered manager explained "everyone wants to be treated equally…I'm confident that staff treat people equally". They went on to explain that this would be discussed at pre-assessment and that they would ensure that staff were respectful.

The service met the Accessible Information Standard for people. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff understood and communicated with people in ways which were meaningful for them. For example, where a person had a hearing impairment, staff ensured that they spoke clearly and were in front of the person so that the person could see them while they were speaking with them. One person had limited sight, they told us that they had not wanted any information provided in a different format but that staff verbally communicated with them effectively. Although the registered manager explained that information was available for people in different formats, this was not always offered unless requested by people. At the time of inspection no-one had requested this but they advised that they would ensure that this was proactively offered to people as part of their care planning process.

People received a service which was responsive to their changing needs and circumstances. One person planned to access an activity in the community regularly. The service had worked to change the times of the person's visits to ensure that they were able to receive support at a time which was reflective of this. Another person had experienced a recent bereavement and the service had been responsive in increasing their support to provide additional assistance and reassurance for the person. An involved professional told us that Fairhope had been able to offer timely assistance where people had needed to receive support quickly, for example, to be discharged from hospital. One person told us "I'm confident that they (Fairhope) would be timely when my needs change". A relative explained "I'd ask for things to be changed and they were responsive to this".

People and relatives told us that they would be confident to complain if they needed to do so and felt that any concerns would be listened to and addressed. People had a copy of the complaints policy in their homes and we saw that where complaints had been raised, these had been acknowledged, investigated and

responded to in line with Fairhope policy. One person explained that they hadn't needed to raise any concerns and said "I haven't needed to complain, the girls (staff) are all nice, helpful and jolly".

People were asked about whether they had any end of life plans in place as part of their assessment and care plans reflected where people had told Fairhope about their preferences. Some people had a medical decision in place regarding their death and copies of these were kept on file to ensure that people's wishes were respected. Some care plans indicated that end of life care had not been discussed with people and the registered manager explained that due to the sensitive nature of this area, they tried to ensure that this was discussed at an appropriate time with people. They explained that they understood the importance of being aware of people's wishes for their end of life care and would ensure that people's choices and preferences were consistently discussed and reflected in people's care plans.

Good

Is the service well-led?

Our findings

People, relatives and staff told us that Fairhope was well led and that the office was easy to contact with friendly staff who were responsive and helpful. A staff member explained that they were "always able to get hold of someone, even out of hours". There was phone support available out of hours for staff, people and their relatives. This was planned and covered by some of the office team who had access to people's basic information and recorded all contacts outside office hours.

The registered manager was available and approachable and feedback from staff was that they felt supported in their role. Staff were clear about their roles and responsibilities and understood the importance of joined up communication with the office. We observed phone communication with staff throughout our inspection and noted that where staff needed to be updated about changes to people's visits or needs, these were texted to staff. Staff understood the need to keep information confidential and told us that they deleted information sent by the service after they had read this.

There were effective systems in place to ensure that staff had the competencies to undertake their roles. They received regular unannounced spot checks which meant that their practice and interactions with people were observed and monitored in areas including infection control, communication and respecting dignity. Staff also received competency checks to ensure that they understood and managed medicines safely and that they were able to move and assist people using the relevant equipment in ways which were safe for people and also staff. These systems meant that the service had oversight about staff skills and were able to highlight and action if any areas for improvement were identified.

The registered manager had regular support from the rest of the office team and also the Nominated Individual. They told us that they were able to discuss practice and any incidents of concerns. The provider attended local meetings with other service to discuss and share good practice and this learning was discussed and shared with the registered manager and other staff. The registered manager explained that they had good working relationships with the local authority and safeguarding teams and sought advice and guidance where needed.

Feedback was sought and used to drive improvements at the service. The registered manager explained that surveys had been recently sent out to people, relatives, visitors and professionals. At the time of inspection 21 surveys had been sent out to people and 5 had been received although some were still being returned. The majority of responses were positive about each question asked with people responding positively when asked whether 'staff are always caring' and whether they were 'treated with dignity and respect'. Where responses were mixed the registered manager explained that when all responses had been received these would be used to consider actions to make improvements. 7 visitor surveys had been sent and three received back at the time of inspection. Again responses were positive including answers to 'always senior staff available to talk to' and 'manager is approachable and receptive'. This demonstrated that the service had systems in place to gather and use feedback to improve service delivery.

Quality assurance measures were in place and used to identify gaps and trends. The management team had

weekly meetings to discuss and agree planned actions and identify priorities for the week. This meant that the office team had a consistent, joined up approach. The registered manager monitored information about different areas of the service including falls, complaints and accidents and incidents but the oversight only recorded that information had been recorded and did not give any detail to identify whether it indicated a trend or pattern which needed analysis and action. Other information was collected and analysed but not on a regular basis. For example, MAR and daily records were collected every few months and analysed by the registered manager. The registered manager told us that they were considering the frequency of when different audits were required to ensure that oversight was consistent. The registered manager and provider were working together to ensure that systems were proportionate and effective for the service people received.

Fairhope worked effectively with other agencies to provide people with joined up care. For example, one person's needs had changed which meant that they were struggling with one staff member for support. The service had contacted the local authority to make them aware and were awaiting assessment by an Occupational Therapist. Staff explained that in the meantime the office had scheduled two staff to assist the person. This meant that both the person and staff were supported until assessments by external professionals could be completed. One involved professional explained that the service communicated well and responded to calls and queries quickly when needed. They explained that they were "really responsive" and were positive about how the service was organised and managed.