Fairway Homecare Limited

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Inspection report

1st Floor
2 Duke Street
Sutton Coldfield
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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Fairway Homecare Limited is a domiciliary care service providing personal care to people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. The service is also registered to provide treatment of disease, disorder and injury although this was not being provided at the time of the inspection. At the time of our inspection 26 people were receiving personal care from the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm; we found systems were not effective in reducing risks to people that resulted from their health needs and the use of prescribed medications. Systems in place to safeguard people from abuse were not robust and processes for learning lessons were not established to drive improvements.

Quality assurance systems were not in place to ensure people received consistent, high-quality and safe care. Following our last inspection, the provider had not implemented the actions required to improve the safety and quality of the service people received. There continued to be a lack of oversight over people's medicines, assessing people's needs and the management of the service.

People did not always feel they were supported in a caring and compassionate way. People and relatives experienced inconsistencies in the caring, respectful approach of staff. However, people with regular staff spoke highly of their diligence. People experienced limited input into the design and review of their support.

People's person-centred needs were not effectively identified and planned for by the service. This meant people sometimes experienced support that wasn't in line with their needs and preferences.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; although the policies and systems in the service were in place to support good 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 30 July 2019) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about missed calls, the safety of care

provided and the governance of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to how people's safety was managed, how people were safeguarding from abuse, people's person-centred needs and how the service was run at this inspection.

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
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 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 rating, we will take action 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Fairway Homecare Limited

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.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service is also registered to provide treatment of disease, disorder and injury although this was not being provided at the time of the 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 (CQC) 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 3 months.

Notice of inspection
This inspection was unannounced.

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 spoke to 3 people and 5 relatives about their experience of the care provided. We spoke with 4 professionals who have contact with the service. We spoke with 11 members of staff including the nominated individual, manager, a coordinator, and 8 members of staff. 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 7 people's care plans, medicine administration records (MAR) and 3 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection we found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a 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.

● People's medication was not managed safely. At the last inspection we found shortfalls in the management of people's medication; these issues had not been rectified. MAR charts were sporadically completed, and records showed some people received medication at inconsistent times, which contradicted how they were prescribed.
● One person's daily records detailed they were being regularly supported with medications that were not detailed in their MAR chart, and these medications were being prepared in a way that may impact their efficacy. This put people at risk of harm.
● People's records were not updated to record their current medication and the support they required. We found care plans and MAR charts were contradictory about people's treatments and the level of support needed to safely manage their medication. One relative advised us of a previous discrepancy where a MAR chart listed an 'as and when required' (PRN) medication as being required several times daily. This put the person at a significant risk of harm. The relative highlighted the error and ensured it was corrected.
● PRN protocols were not always in place to guide staff about when to administer medications for occasional use. Where PRN protocols were in place, they did not always have enough detail about when a medication was required.
● People's health needs and associated risks were not safely managed. For example, people who required support with catheter care, diabetes or weight loss did not have specific care plans in place. In addition, there was no system for recording and monitoring people's epileptic seizures. Staff were not always knowledgeable about managing these risks. Some people and relatives told us they had to explain their needs to staff, who did not always know about their conditions.
● People who were distressed were not supported safely. We found some people were experiencing an escalation in incidents of distress. However, care plans did not always give clear guidance to staff and there was no system for recording and reviewing these incidents. Staff were not always clear on how to deescalate people's distress. This put people, staff and relatives at risk of harm.
● Risk assessments did not contain any information to guide staff in the event of a fire. Some staff supported

people for 12 hour visits at day or night. However, consideration had not been given in care plans to how staff would safely support people in the event of a fire. The manager had identified this shortfall and planned to address this through a thorough update of the care plan system.

● People did not always receive the support they required to keep them safe. Some relatives informed us that staff who supported their loved ones at night were found sleeping. One of the people who experienced this had a serious condition that required monitoring at night; this put them at a significant risk of harm.

● There was no clear system in place for recording and reviewing accidents and incidents. Staff were unsure where such matters should be recorded. As a result, there was no opportunity to review incidents to identify trends and take action to reduce ongoing risks. This put people at risk of harm.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and the welfare of people using the service. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People and relatives did not always feel the service they received was safe. Those who were generally happy with their support reported inconsistencies in the quality and safety of care from different staff members. One relative told us they were worried staff wouldn't act to keep their loved one safe, if needed. They said, "These people are my eyes and ears. If something is wrong, what are they going to do? These things are the real basics."

● Allegations of abuse were not always reported or investigated. We found incidents or concerns about people's safety had not been acted upon. For example, the provider hadn't taken enough action to safeguard a person who had an unexplained injury. The provider hadn't raised the matter with the local authority as a safeguarding alert and no records relating to the incident were kept. This put people at risk of ongoing potential abuse.

● Not all staff had completed safeguarding training. Records showed several staff did not have valid training for safeguarding adults. Staff understood the need to report any concerns of abuse but were unclear about how such matters should be recorded.

The provider had failed to take action to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was a system in place to log when staff attended visits and how long they spent with people. However, there was no system in place for reviewing these records to identify any issues.

● Where people were supported by regular staff, they were satisfied with the amount of time staff members spent with them. One person said, "I do like that they give you the time, they are here for the time of the call and the majority are not cutting corners or rushing you along."

● Staff had been recruited safely. Pre-employment checks had been carried out including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Not all staff were up to date with infection control training. However, staff were knowledgeable about the use of Personal Protective Equipment and people and relatives felt staff managed infection risks appropriately.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not adequately assessed, recorded and reviewed. People's care plans lacked detail about their specific needs and how to mitigate any associated risks. For example, 1 person's care plan consisted of a list of medical conditions, with no further information about how these impacted the person or what support they needed to manage them.
- Some people's records were contradictory about the person's needs and had not been reviewed for over a year. For example, 1 person's falls risk assessment was over two years old and had not been reviewed following a significant fall. The assessment stated the person was at low risk of falls and did not contain key details about the previous fall and how this risk could be mitigated. This put the person at a continued risk of harm.

Staff support: induction, training, skills and experience

- New staff received an induction and shadowed experienced staff before working independently with people. New starters felt well prepared for their roles at Fairway Homecare Limited. However, some people and relatives felt new staff lacked the skills and knowledge required to meet their needs.
- Staff were not always up to date with key training. Records showed around a third of the staff team had not completed current training in core subjects such as infection control, fire safety and moving and handling. Following the inspection, the new manager took action to ensure the staff team had received refresher training, and more specialist training such as dementia and diabetes awareness.
- The provider had fostered strong links with a training organisation that trained new staff for a career in social care. Staff who had been employed through this programme spoke enthusiastically about the process and felt well-equipped for their role.

Supporting people to eat and drink enough to maintain a balanced diet

- Where people were at risk of losing weight, systems were not in place to ensure people received updated support in line with their changing needs. People who required support and encouragement with their nutritional intake did not always consistently get the help they needed. One relative informed that they had implemented their own records for their family member, due to concerns about how they were being supported at mealtimes.
- People's preferences about the food and drink they enjoyed were recorded in their care plans. Staff were knowledgeable about people's mealtime routines and their likes and dislikes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

● Professionals reported the provider was not always responsive to emerging issues and communication with other agencies wasn't effective. This meant stakeholders were not always assured about the effectiveness of service that was being provided. One professional told us, "I can't say I find them responsive. They [the manager or provider] are not in the office when I make contact."

● Staff understood when external services may be required and felt able to report any changing healthcare needs for people. One staff member gave an example of aids they had requested to support a person with their dementia and how this had been beneficial to them.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● People had not always consented to their care plans. Where people lacked capacity to consent to these decisions, the MCA was not always followed. For example, we reviewed a document that had been signed by the previous manager on behalf of a person who lacked capacity to do this themselves. The person's family had not been involved as part of their best interests.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. Some relatives told us about loved ones being left without timely personal care, which compromised their dignity. Another relative described staff lacking sympathy, patience and understanding in their approach. They said, "It's the difference between providing care and being caring. They should say, hang on we'll give you a minute. That doesn't happen."
- People and relatives experienced inconsistencies between how caring different staff members were. One relative told us, "Some are good, some aren't. Some are absolutely amazing." Another person said, "Generally the care is good, you do get the odd staff member that doesn't match up to standards."
- People who had regular staff had a more positive experience of the staff who supported them. One person explained they had difficulties with new staff members that did not know their needs. However, they added, "My main 2 carers from the beginning were absolutely superb."
- Staff spoke positively about the people they supported and their role. One staff member told us how they had noticed a positive change in the approach of new staff. They said, "I've met new carers and it's lovely to see the bond they have with clients. They are affectionate and attentive to their needs. It really makes me smile."

Supporting people to express their views and be involved in making decisions about their care

- People did not always feel involved in decisions around their care. For example, 1 person said, "I think the company isn't as good as it was a few years ago. If there are any changes, they don't let me know. If they change the carers, they should ring and tell me."
- There was no system in place for reviewing people's evolving needs and ensuring people received ongoing consultation about their support. This meant there were limited opportunities for people and relatives to be involved in decisions and express their views.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care was not designed to reflect their needs and meet their preferences. For example, 1 person's religious needs and wishes were not fully explored and documented in their care plan. Another person told us how they were not always supported by staff of their preferred gender. This meant people did not have maximum choice and control over the service they received.

● Care plans and risk assessments were not updated to reflect people's changing needs. One person's health needs had changed significantly but their records had not been amended to show their current requirements. Another person's care plans did not reflect changes to the how often they required staff to attend.

● People's plans were not regularly reviewed to ensure their preferences were met. We found care plans had not been reviewed after people's initial assessments. This meant that many records had not been updated for a few years and contained incorrect and outdated information.

The provider had failed to ensure care was designed collaboratively with people, so it reflected their needs and met their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's care plans contained minimal information about their communication needs. This meant that staff did not have access to relevant information about how best to communicate and interpret people's needs.

Improving care quality in response to complaints or concerns

● There was a system in place for responding to complaints and concerns. However, some of the issued we identified during the inspection, that had been raised with the provider, had not been addressed through these channels. This meant we could be not assured that the complaints system was being implemented effectively.

● Relatives reported an improvement in how concerns were responded to since the new manager started at

the service. One relative said, "Of late things have improved, but Rome wasn't built in a day." Another relative told us, "I've heard horror stories, a lot of bad things were happening. But things have improved."

End of life care and support

● People's end of life wishes were not explored in their care plans. However, there was no one receiving end of life care at the time of inspection.

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

At our last inspection we found the provider had failed to ensure effective systems were in place. 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.

- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service.
- Record keeping at the service was poor and there was a lack of ownership of oversight responsibilities at the service. The manager and nominated individual were unable to locate any auditing systems, safeguarding records and incident records. The previous systems completed by the former registered manager had not been continued by the new manager.
- Processes had failed to identify and address shortfalls in the safety of medication administration, which put people at risk of harm. Following the inspection, the manager reviewed people's medication needs to ensure records were correct.
- Governance systems had failed to highlight and rectify deficiencies in the management of people's health conditions and associated risks. In addition, systems for escalating allegations of abuse and neglect were inadequate, which put people at risk of continued harm.
- The provider's processes failed to assess and deliver support in line with people's person-centred needs and preferences. This not only impacted the quality of people's experience, it put people at risk of harm.
- Systems to audit the quality and safety of the service were not consistently carried out. Audits had not been completed for several months and the provider had not completed additional audits after the previous manager left the service. This meant there was no oversight of the quality and safety of the care provided; this was in breach of the provider's own policy.
- Governance processes had failed to ensure accurate and up to date records of relevant matters were documented and actions taken. Incident and safeguarding records had not been completed for several months, despite relevant matters occurring within that time. This was in breach of the provider's own policies for incidents and safeguarding adults.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We identified that CQC had not been notified about several safeguarding incidents that had been raised with the local authority. This was raised with the manager and nominated individual for action.

● Systems in place for reviewing accidents, incidents and complaints were not robust. Records had not been completed for several months and matters CQC had prior knowledge of, or that came to light through the course of the inspection, were not documented. This meant there were no assurances that appropriate actions had been taken in response to concerns or risks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was no established system to seek feedback from people, relatives and professionals. We requested copies of the most recent survey and analysis of the results; this information was not provided to be reviewed as part of the inspection.

● People and relatives knew who the new manager was and what steps to take to raise any issues they may have. They found the new manager approachable if they had concerns.

● Staff felt confident in the new manager and felt any issues they had would be listened to and addressed. One staff member told us, "[The manager] doesn't wait around, things are actioned straight away. I can see massive changes. When speaking to other staff, they seem upbeat."

Continuous learning and improving care

● Systems and processes were not always established to maintain oversight of the service and identify meaningful learning. This meant there were missed opportunities to drive improvements.

● People, relatives and staff reported that they had noticed an improvement since the new manager started their role. One relative informed that the communication had improved, and they felt more updated about their loved one's care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received care and treatment that was appropriate and met their needs and preferences. They failed to ensure care was designed collaboratively with people and reflected their current person-centred needs.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to effectively assess and document people's needs and manage associated risks. This put people at risk of harm.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to effectively investigate, and take action to prevent, any allegation or evidence of abuse. This put people at risk of abuse or improper treatment.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance, including assurance and auditing

systems and processes. They failed to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of people's experience.

The enforcement action we took:

Impose a condition