

Fairway Homecare Limited

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Inspection report

Unit 8
Trinity Place, Midland Drive
Sutton Coldfield
B72 1TX

Date of inspection visit:
09 April 2019
15 April 2019

Date of publication:
30 July 2019

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service: Fairway Homecare Limited is a domiciliary care service registered to provide personal care to people in their own homes. At the time of the inspection 29 people were receiving personal care from the service.

People's experience of using this service:

Systems around medicine management needed improving. You can see what action we told the provider to take at the back of the full report.

Care plans and risk assessments were not in place for all of people's known risks. Where care needs had changed care plans and risk assessments had not always been updated to reflect people's most current needs. This placed people at risk of receiving unsafe care.

Governance systems were either not in place or not robust. This meant that systems were not effective in monitoring the quality and safety of the service. You can see what action we told the provider to take at the back of the full report.

The provider took immediate action to begin to address the shortfalls identified through the inspection and has kept us updated on improvements that have been introduced.

Staff had received mandatory training although we found improvements were needed in providing specific training around people's individual needs. Staff felt supported by the management of the service.

People felt cared for by the regular staff who supported them. Some relatives reported that people did not always receive regular staff and that had had an impact on their relatives care. People had been involved in planning and reviewing their care and were supported to have choice and control of their lives.

Rating at last inspection: This was the services first inspection at this location.

Why we inspected: This was a scheduled inspection

Follow up: We will continue to monitor the service and will inspect following our re-inspection programme. We may inspect sooner should we receive any concerning information.

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

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 always safe

Details are in our Safe findings below.

Requires Improvement ●

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 always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of one inspector.

Service and service type: The 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager would be available to support the inspection. Inspection site visit activity started on 9 April 2019 and ended on 18 April 2019.

What we did:

We reviewed the information we had received about the service since they were registered. We sought feedback from the local authority who commission packages of care from the service.

During the inspection we spoke with one person and the relatives of three people to ask their experience of the care provided. We spoke with the registered manager, registered provider, care co-ordinator, clinical educator and three members of care staff.

We visited the office location on 9 April 2019 to see the manager and office staff; and to review care records and policies and procedures. We carried out phone calls to people, staff and relatives on the 11, 15, 16 and 18 April 2019. At the site visit we looked at four people's care records to see how their care was planned and

delivered. Other records we looked at included three staff files to check suitable members of staff were recruited and received appropriate training. We also looked at records relating to the management of the service to ensure people received a good quality service.

Details are in the key questions below.

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely

- Systems around medicines management required improvement. We found that there were no medicine administration records (MAR) charts to record the daily medicines people had taken. MAR charts are a tool used to record all the medicines people are taking and for staff to sign these once they have supported a person to receive their medicines. This improves the safety of medicine administration.
- Whilst staff had received medication training the provider had not carried out checks to ensure staff were safe to administer medicines.
- We found one person often refused to have one of their medicines. Whilst the registered manager informed us that they had contacted the GP about this there was no documentation available or plan in place to ensure this person's well-being was protected.
- Following the inspection we were informed of a medication error resulting in investigation by relevant partner agencies. The provider took immediate action to safeguard people.

A failure to have systems in place for safe medicine management is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider took immediate action upon receiving feedback of our concerns to begin to implement systems to improve the medicine management at the service.

Assessing risk, safety monitoring and management

- Care plans and risk assessments were not in place to mitigate all of people's known risks. For example one person was living with epilepsy. There was no care plan or risk assessment in place to guide staff of action to take should this person have a seizure. The provider had not ensured staff had clear guidance in place to minimise the risks associated with people's care.
- Care records were not always up to date and did not always provide staff with clear instructions on how to support people safely. For example, one person had recently been diagnosed with diabetes. There was no care plan or risk assessment in place to mitigate the risks for this person.
- People told us they felt safe whilst receiving care from staff. One person told us how staff helped them feel safe and told us, "They [staff] make sure I've got my care alarm next to me before they go." Relatives informed us they thought staff understood the risks associated with their relatives care.
- There was a system in place to ensure people had received their calls.

A failure to prevent avoidable harm or risk of harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider took immediate action upon receiving feedback of our concerns to review people's risks and put appropriate guidance in place to ensure people's risks were mitigated.

Systems and processes to safeguard people from the risk of abuse

- People were supported by staff who understood the signs of abuse and appropriate action to take should they have concerns. Staff had received safeguarding training and were able to describe the action they would take to report any concerns.
- The registered manager understood their responsibility to respond to safeguarding concerns raised with them including informing the local authority.

Staffing and recruitment

- People told us that the correct number of staff were available to support them.
- Staff were recruited safely. We saw that the providers recruitment process included obtaining a Disclosure and Barring Service Check (DBS) to determine whether staff were safe to work with people. We found that references weren't consistently validated to ensure they were credible. Doing this would further assure the provider that robust checks had been carried out on the staff members past employment history.

Preventing and controlling infection

- Staff were able to tell us how they ensured good infection control standards. We saw staff receiving supplies of personal protective equipment such as gloves when they visited the offices.

Learning lessons when things go wrong

- Incidents such as safeguarding concerns were dealt with appropriately as and when they occurred. However, there were no systems in place to learn from incidents or identify possible themes in order to reduce the chance of a similar incident occurring again.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA,
- We found that the service was not consistently working in line with the principles of the MCA. Whilst many people using the service were deemed to have capacity there had been no assessments carried out for those people who may not have had capacity to make some decisions.
- Staff we spoke with could describe how they ensured they gained people's consent before supporting them and gave people daily choices around their care. One staff member told us, "I make sure I ask them what they want."
- The provider informed us that refresher training in the MCA was due to be provided to staff shortly after the inspection.

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

- People's needs were assessed prior to the person receiving care from the service. The registered manager explained that they would only agree to provide care to people who they could safely support and for whom they had the correct staffing levels for.

Staff support: induction, training, skills and experience

- Staff received training from an external training provider. Whilst mandatory training was provided to staff we found improvements were needed in providing training around people's specific needs. For example, staff had not received training in topics such as dementia or diabetes despite supporting people who were living with these conditions.
- Staff informed us that they felt the training they had received had helped them in their roles. We saw that staff received supervisions. Whilst we were informed that the care certificate was embedded into the mandatory training there was no evidence available that staff's competencies had been tested following completion of the care certificate.
- People told us they staff had the right skills and knowledge to support them. One relative told us, "The majority [of staff] are skilled in what they are doing."

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

- People's preferences for food and drink were detailed in their care plans. Many people lived with their relatives who were responsible for food preparation.
- Where staff did support people with meals they were able to tell us how they made sure they offered people choice at meal times.

Staff working with other agencies to provide consistent, effective, timely care

- The registered manager was able to provide examples of working with other healthcare professionals such as district nurses to ensure people received the correct specialist support when they needed it.

Supporting people to live healthier lives, access healthcare services and support

- Staff were able to inform us about some people's healthcare needs. Staff described the benefit of seeing people regularly as they were able to tell if a person was unwell.
- We saw the service acting responsively to a healthcare emergency for a person during the inspection. Medical advice was sought and staff went out to support the person.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

- The providers systems did not support the service to be fully caring. For example, people could not be assured that their care plans contained accurate information about their current care needs, medicine management was not always safe and people had not consistently had their rights upheld under the MCA.
- Some relatives shared that they did not always have consistent staff. One relative told us, "People who know her is what she needs." Inconsistency of staff impacted on peoples care as some people liked routine and seeing familiar staff helped them feel comfortable being supported. We spoke with the provider about this who agreed to look into this.
- People felt cared for by the staff who supported them. Relatives were happy with the regular staff who supported people and one relative told us, "Yes they are caring. Nothings too much trouble- if they can help out they do."
- Staff we spoke with told us they enjoyed their role and had got to know the regular people they supported well. One staff member told us, "I like to have a good rapport with people"

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

- People and their relatives had been involved in developing a care plan based around their needs and wishes. One relative told us, "They came out and spent a couple of hours going through things what we expect and all health and safety aspects."
- Staff were able to inform us how they ensured they offered choices in people's care such as what to eat or what clothes to wear.

Respecting and promoting people's privacy, dignity and independence

- People informed us they felt staff treated them with dignity. Staff were able to describe methods they used to ensure people's dignity was respected such as covering people with a towel during personal care.
- One staff member told us how they promoted a persons independence when supporting them to make a drink and described this process as, "Letting people do what they can do....I'm helping but not taking over."

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- We found that people's care plans did not consistently contain accurate and up to date information about people's care needs. For example, one person's care plan stated that they were using incontinence aids and were confined to bed, which when we spoke with the registered manager confirmed that this was not the case anymore. This meant there was a risk that people would not receive care how they wished.
- We found that when people's needs changed care records had not been updated to reflect these changes.
- Relatives informed us they had been involved in initially compiling a care plan that reflected people's care needs along with likes and dislikes. Relatives informed us that staff informed them of any changes in their family members care, for example a change in a person's healthcare need.
- Relatives told us that there were reviews of care planned. One relative told us, "We have got an appointment this week for the six monthly review to see if we are still happy with the service." Whilst reviews had taken place they had not been effective in identifying that care records did not contain accurate information about the person's current needs.
- Staff were aware of people's preferences for care and one staff member explained how they had got to know people's family background.

Improving care quality in response to complaints or concerns

- We were informed that there was a complaints procedure in place. However, no complaints had been received over the past year. Relatives we spoke with were aware of the way to complain and informed us that any concerns raised were usually dealt with efficiently. One relative told us, "Any problems or changes they will act on."

End of life care and support

- No one was currently receiving end of life support from the service.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not have an effective system in place to monitor the quality and safety of the service.
 - Systems that were in place were not effective and had failed to identify that people's known risks had not been mitigated and that care records were not up to date.
 - Systems had failed to identify that medicine management was not safe as competency checks had not been carried out and MAR charts were not in place.
 - Whilst there were systems to monitor that care calls had taken place, these systems had not identified that people were not always receiving regular care staff which had an impact on some people's care.
 - There were no systems in place to have oversight of incidents that had occurred at the service. This meant that incidents had not been learned from to try and put measures in place to reduce the risk of reoccurrence.
 - Monitoring systems had not highlighted that the training matrix was not up to date. This meant that there was a lack of oversight of when training had been completed and needed renewing.
 - Whilst the provider advised that they carried out regular checks at the service there was no record of these and no robust governance system in place to have oversight of the service.
- A failure to have robust and effective governance systems in place is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has acted responsively following the inspection and has been open and transparent in their responses to us. The provider sent us plans of immediate action they had taken to improve the monitoring of the service and timely action to check on the safety of the people receiving care.

- ☐ The registered manager had failed to notify the commission of two separate safeguarding incidents.

A failure to notify the Commission of specific events and incidents is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives informed us that they thought the registered manager was responsive to requests they had made and one relative informed us that the registered manager, "Usually does respond very quickly."
- Staff felt supported in their role. One staff member told us they could always seek advice when needed and said, "I can approach the registered manager or care co-ordinators. They are very approachable and I can get hold of them."

Continuous learning and improving care

- The registered manager informed us that they had sent out satisfaction questionnaires to people in October 2018 but had had no responses. There were plans to re-send these out to gain people's views of the service. Staff questionnaires had been completed but the results of these were not available at the inspection.
- We saw that spot checks took place to check that people were happy with their care. In addition these were used to monitor staff performance whilst they were supporting people.

Working in partnership with others

- The service worked with other healthcare professionals such as district nurses to ensure people received consistent care.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A failure to have systems in place for safe medicine management. A failure to prevent avoidable harm or risk of harm.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A failure to have robust and effective governance systems in place