Strathmore Care

Fairview House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on the 5, 6, 8 and 9 March 2018.

At our previous inspection in July 2017, we rated the service Inadequate and the service was placed in Special Measures. Following our inspection in July 2017, we sent an urgent action letter to the provider informing them about our findings and the seriousness of our concerns. We requested an urgent action plan from the provider telling us what they were going to do immediately to address our concerns. We took enforcement action and imposed conditions on the provider's registration, which included a restriction on preventing any new admissions to Fairview House. You can read the full report from our last inspection on 17, 18, 20 and 28 July 2017 by selecting the 'All reports' link for Fairview House on our website at www.cqc.org.uk.

Services in Special Measures are kept under review and inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and the rating of Inadequate remains for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Our inspection in March 2018 was carried out to check the actions and improvements the provider told us they would make to achieve and maintain compliance with the fundamental standards under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Our findings showed that insufficient improvements had been made since our last inspection and people remained at risk of receiving unsafe care and treatment. The Commission is currently considering its enforcement powers.

For adult social care the maximum time for being in Special Measures will usually be no longer than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as Inadequate for any of the five key questions it will no longer be in Special Measures.
At this inspection the overall rating of this service is Inadequate and the service therefore remains in 'Special Measures'.

Fairview House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 55 older people. There were 39 people living at Fairview House when we visited the service on the 5 March 2018.

At our inspection we identified a continued lack of governance, and people remained at risk of unnecessary harm. The systems and processes in place to effectively monitor and improve the quality of the service were not robust. The provider had not taken appropriate steps to ensure they had clear scrutiny and oversight of the service which ensured people received safe care and treatment. The lack of managerial oversight had impacted on people and the quality of care provided and had failed to identify and address concerns and breaches of regulatory requirements.

There had not been a registered manager in post at the service since June 2015. A manager had been recruited in January 2018 who was not yet registered with the Care Quality Commission. 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.

Improvements were required to ensure sufficient numbers of staff were effectively deployed, so that people's individual care and support needs were met.

The service had not always taken appropriate action with regard to safeguarding concerns. Although staff had received safeguarding training and knew how to report abuse, not all staff were aware of external whistle blowing procedures.

The standard of record keeping was of a poor standard. Care records were not accurately maintained to ensure staff were provided with clear up to date information which reflected people's care and support needs. Risks to people had not always been identified. Where risks had been identified people's care records had not always been reviewed and, where appropriate, updated.

Staff completed the provider's mandatory training but had not received specialist training to equip them with the skills, support and knowledge they needed to provide effective good quality care to people with specific health needs. Although staff felt supported, staff supervision was infrequent and not in line with the provider's policy.

Improvements were required to ensure people received their medicines as prescribed, and appropriately trained staff were available at all times to administer people's medicines.

Staff had received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), however improvements were required to ensure MCA assessments were undertaken correctly, and reviewed appropriately, in line with the MCA Code of Practice.

Generally, people were positive about the meals provided. There was a choice of food and drinks each day. However, documentation used to monitor people's daily fluid intake were not always being completed, placing them at risk of dehydration and/or poor nutritional intake.

Improvements were required to provide people with meaningful activities and support to pursue their hobbies and interests.

Whilst most staff were kind and caring towards the people they supported, they were often task orientated due to the deployment of staff. People were supported to maintain relationships with people who were important to them and visitors were welcome at the service at any time.

At this inspection we found breaches of Regulations 9 [Person centred care], 12 [Safe care and treatment], 11 [Consent], 13 [Safeguarding service users from abuse and improper treatment], 14 [Meeting nutritional and hydration needs], 15 [Premises and equipment], 17 [Good Governance] and 18 [Staffing] of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks associated with people's health, safety and well-being were not always managed safely.

Improvements are required to ensure sufficient numbers of staff are effectively deployed to meet people's individual care and support needs.

Safe systems were in place for staff recruitment.

Is the service effective?

Inadequate

The service was not effective.

Improvements were required to ensure care records were completed and monitored effectively. This included people's daily fluid intake and repositioning charts.

Staff had a basic understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Standards. People's rights and freedoms were not always protected.

Staff completed mandatory training but there was no evidence to demonstrate staff had received specialist training to enable them to effectively carry out their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff treated people with kindness and compassion, however they were often task orientated and routine led.

People were supported to maintain contact with family and friends.

Is the service responsive?

Inadequate

The service was not responsive.

Improvements were required to ensure people's care plans and associated risk assessments were up to date and reflective of their care and support needs.

Improvements were required to ensure people were engaged in meaningful activities and supported to pursue hobbies and interests.

There was a complaints policy in place and concerns raised had been dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager.

There was a lack of governance and managerial oversight by the provider. Improvements were required to ensure the systems and processes in place to assess, monitor and mitigate the risks to people's health, safety and welfare were robust and effective.

Fairview House

Detailed findings

Background to this inspection

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

This inspection took place on 5, 6, 8 and 9 March 2018 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the first day the inspection team consisted of three inspectors and an expert by experience. On the second day the inspection team consisted of three inspectors. On the third and fourth days of our inspection the inspection team consisted of two inspectors.

Not everyone was able to verbally share with us their experience of life at the service due to living with dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We also looked at the environment including communal areas and some people's bedrooms.

During our inspection, we spoke with 16 people living at Fairview House, two relatives, one visitor and two healthcare professionals to gain their views about the service. We also spoke with the home manager, deputy manager, managing director and the provider's representative for Strathmore Care. We spoke with eight members of care staff and the chef and spent time observing the support staff provided to people.

We looked at a range of records including seven people's care plans, staff training, five staff files, rostering information, shift handover logs, arrangements for the management of medication, records of accidents and incidents and quality assurance information.

Inadequate

Our findings

At our last inspection in July 2017, dependency assessments to calculate staffing levels had not been undertaken since March 2017. At this inspection, a monthly dependency tool was being used; however we found there were inconsistencies in the information used as people's dependency needs were not always accurately recorded. For example, the dependency tool had not been reviewed following a change in the care and support needs of a person who was receiving end of life care since their discharge from hospital on the 27 February 2018. Furthermore, the dependency tool for March 2018 showed one person was at low risk with regard to their mobility care needs. It was evident no consideration had been taken into account regarding the eight falls the person had sustained during the period 1 January 2018 to 23 February 2018. Also, although consideration had been given to the delivery of care whilst the passenger lift for the service was out of use pending the installation of a new lift, in practice we observed these not to be fully effective with regard to staffing numbers and the deployment of staff. One member of staff expressed concern that staff's time to support people had been impacted by the passenger lift for the service not being available for use.

During our inspection, we observed people sitting in the communal lounges, many of whom were asleep. For example, on the 6 March 2018 at 07:40, there were 10 people sitting in the first floor lounge, of whom six were asleep. There was no staff presence in the lounge. One person was slumped forward in their chair, their head leaning forward towards a table. An inspector had to intervene to prevent the person from falling forward and potentially sustaining an injury.

People told us they were concerned about staffing levels and how this had affected their care and continuously made them feel less safe. One person told us staff did not always ensure they had access to their call bell and they had to shout for help. The person told us, "They don't always give it [call bell] to me and I forget to ask sometimes. It doesn't always work anyway and then I'll just shout for help." They went on to say they suffered from severe anxiety and said, "I do get scared sometimes, so I need to be able to call them. When they come they are very good at calming me down." Another person said, "They're normally too busy to chat to me."

Relatives also shared similar concerns. One relative told us, "[Person] needs two carers to be hoisted so they have to wait for two to be available. If they want to go to the toilet at a busy time, they can wait for 30 minutes." Another relative said, "There is not enough staff here. It means, for example, there's a potentially lovely garden out there but it's in a bad way so the people can never go out and get some fresh air, it's too dangerous." A visitor told us, "They're short staffed definitely; they don't have time to spend with people."

We remained concerned about the effective deployment of staff as areas of the service including the communal areas went unsupervised at different times during our inspection. Staff also didn't consider their position in the service whilst undertaking other duties, such as completion of daily records. We found staff congregated in one area of the service, instead of deploying themselves in such a way that larger parts of the communal areas could be supervised and supported to increase safe monitoring of people's care. This had been discussed with the provider at the last inspection, following a person falling in one of the communal lounges when staff were not in the vicinity.

The staffing levels as quoted by the home manager at the start of our inspection was eight staff on the morning shift (two senior members of staff and six care assistants) this being from 08:00 to 14:00 and seven on the afternoon shift (one senior member of staff and six care assistants), this being 14:00 to 20:20. With night cover being four staff (one senior member of staff and three care assistants), from 20:00 to 08:20. During our inspection we found staffing levels were being maintained however, on review of staff rotas, including staff signing in and out sheets, we found a number of entries where staff had either signed 'in' or not 'out', or vice versa, creating a position of verifying factual attendance impossible. We also noted staffs' beginning and ending of shift times varied. For example, on 27 February 2018, the signing in sheet indicated start times on 'am' duties as 07.50, 07.55, 09.20, 08.45, 07.45, 07.50 and 07.55. It was therefore difficult to assert that staffing ratios of two senior care staff plus six care assistants were complied with.

The above failings constitute a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited a person in their bedroom we noted their call bell was out of reach. The person told us they had mentioned this on numerous occasions to staff. They went on to inform a member of the inspection team that on one occasion a member of staff had told them off for pressing their call bell, telling them, "This is only to be used for emergencies". They went on to say when they had needed something they tried to do it themselves but had a fall and were on the floor for 45 minutes before staff assistance was provided.

We found another person's call bell was not working properly. They told us they were concerned as their door was always closed and staff would not know if they were to have a fall. On the 5 March 2018, we pressed their call bell at 12:04 and again at 12:06. Following failure to respond to the call bell we pressed a call bell in another person's bedroom. Three members of staff arrived at 12:13. We discussed our concerns with the call bell system with the home manager and were assured there were no issues with the system. However, when we returned to Fairview House on the 6 March 2018 and visited the person in their bedroom at 08:46, they told us their call bell was not working. We noted the call bell was inaccessible and had fallen down the side of the person's bed. We pressed the call bell at 08:48 and the home manager entered the room at 08:54. The home manager was undertaking a welfare visit to the person and was not responding to the call bell. The home manager was surprised the call bell was not working and informed us they had personally followed this up when we had raised concerns with them on the 5 March 2018. We could not be assured that effective systems were in place to monitor the call bell system within the service so that people using the service could summon assistance.

At our previous inspection in July 2017 we found improvements were required to ensure the risks to people's safety and wellbeing were mitigated. At this inspection, people were not being kept safe from the risk of harm because their care was not being effectively managed to mitigate or reduce identified/potential risks from occurring or reoccurring. This included ensuring relevant and necessary information was made available to staff to enable them to keep people safe whilst assisting them with their individual care and support needs.

At our previous inspection in July 2017, we found no formal analysis had been undertaken of incidents and accidents, falls (witnessed and unwitnessed) and safeguards to identify trends and put measures in place to mitigate reoccurrence. At this inspection the provider was unable to demonstrate robust analyses had been implemented. For example, during January 2018 there had been 32 falls at the service. Whilst dates and information such as location, times of falls and whether people sustained an injury were recorded, no further in depth analysis had been undertaken such as actions recorded to mitigate further falls. For example, records showed one person had sustained seven falls during the period January and February 2018. Despite referrals to the local falls prevention team on the 23 June 2017 and 09 October 2017, the person's mobility care plan and risk assessment failed to indicate what actions the service was taking to mitigate the risk of recurrent falls. We also found another person who had had sustained eight falls during the period 1 January 2018 to 23 February 2018. A dependency profile for the person had identified they were at low risk of falling. An undated falls risk assessment identified them as being at medium risk of falling however had this risk assessment been reviewed following the person's falls the overall risk score would have deemed them as being at high risk of falls.

We identified concerns with the administration of medicines at our inspection in July 2017. Whilst some improvements had been made, and despite assurances from the provider following our inspection in July 2017 that effective systems would be implemented, we continued to find creams prescribed to other people in people's bedrooms. When we discussed our findings with the home manager they could not provide a rationale as to why these creams were in people's bedrooms or able to demonstrate robust checks had been undertaken since our last inspection. Topical medicines application record sheets were not being fully completed including marking the site of application on body charts. For example, the topical medicines record for the month of February 2018 for one person recorded a layer of emollient should be applied three to four times a day. These instructions had not been followed for 10 out of 28 days and no cream was applied. It was also recorded within another person's topical medicines record for February 2018 that their cream should be applied daily. Their medicines record recorded that the cream had only been applied nine times during the month.

On the 7 March 2018 we observed a member of staff administering medication to a person directly using their fingers, without any gloves or use of a spoon, potentially placing the person at risk due to poor infection control processes. We also observed another member of staff administering medication to another person. The staff member was heard saying, "It's only water, its only water" whilst offering the person a teaspoon containing a white tablet and a liquid. This is considered covert administration of medication. The person was observed to refuse to take their medication by spitting out the tablet. The member of staff picked the tablet up from the floor. On reviewing the person's medication care plan we found they had diabetes type 2 which is tablet controlled. We found no evidence to demonstrate a review had taken place or actions the service had taken, to ensure the person received their medication as prescribed when they refused to take these. In addition, we noted their care plan did not contain any information about their medication being administered covertly.

We also found one person's pain relieving patch administered on 2 March 2018 had been changed on 8 March 2018, one day earlier than it should have been. The instruction for this medication stated there should be a clear gap of seven days before the pain relieving patch should have been changed. This is not good medication administration practice and was not in line with the prescriber's instructions. Pain relieving patches are slow release medication and mismanagement of administration could result in the person not receiving the complete dosage of their prescription.

At our previous inspection, we found no observations of staff practice had been undertaken to ensure they remained competent to administer medication. At this inspection, we found competency assessments had

been completed for four members of staff between 30 September 2017 and 2 October 2017. A further four members of staff had received competency checks between January and February 2018. No evidence was provided to us to demonstrate proactive action had been taken by the provider immediately following our inspection in July 2017. This showed it had taken several months for the provider to ensure that all staff received observations of their practice despite our concerns.

Although the provider had assured us in the form of monthly reports to the Commission, that each shift had a senior member of staff on duty, we found this was not always happening for the night shift. For example, the staff signing in sheets for 16, 23, 24, 25, 26 and 27 February 2018 showed there were no senior staff member on duty throughout the night shift. This meant there was no competent, qualified person working at Fairview House to administer medication to people if required.

The above failings constitute a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection, cleaning schedules had been implemented and the environment of the home was observed to be much cleaner. However, the flooring in one person's room continued to be soaked in urine and the hand basin in their room was dirty and lime scaled. Staff told us this was due to the person's mental health condition and staff being frightened to enter the person's room. We also continued to find broken/chipped furniture in some people's bedrooms. This presented an infection control risk and the risk of harm to people, relatives and staff. In one person's bedroom, we saw a broken wooden jagged dado rail, which we had to bring to the immediate attention of the provider to ensure no one, was injured or harmed. The provider took appropriate action to address this.

The above demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, the service had failed to recognise a potential safeguarding concern for a person living at Fairview House. Moreover, the service had not involved other healthcare professionals to try to support the person. We had found the person living in very unpleasant conditions. We requested a safeguarding alert to be raised immediately with the local authority. On the 28 July 2017, eleven days after our initial request, a safeguard alert had still not been raised. We were assured an alert would be made immediately however the local authority did not receive the safeguard alert until the 7 August 2017, 22 days following our request. This showed that safeguarding concerns were not completed in a timely manner.

At this inspection we looked at the actions taken by the service for the person and could not evidence what on-going action had been taken to support the needs of the person since our last inspection up until the new home manager commenced their employment in January 2018. The deputy manager was unaware of the background and outcome of the safeguarding investigation. We found no evidence to demonstrate appropriate action had been taken to mitigate the impact on the person's health and well-being prior to the home manager starting work at the service.

Staff we spoke with confirmed they had received safeguarding training. However, only three members of staff were aware of the role of the local authority regarding safeguarding. None of the staff spoken with were aware of where to obtain information regarding external whistle blowing procedures.

The management team were unable to demonstrate and evidence thorough analysis was undertaken following safeguarding concerns; this included the completion of investigation reports. For example, one person had been admitted to hospital with severe dehydration in November 2017. No report, including

lessons learned to improve the safety for people living at Fairview House had been completed, such as ensuring robust monitoring of people's fluid charts.

During our inspection, we found handwritten notes in one person's care file. These were undated but suggested the person was unhappy with some members of staff, calling them 'lazy', 'bad', and that the police should be called. There was no evidence to show what actions the service had taken in response to these negative comments about staff. This was a potential safeguarding issue however the service had failed to address or evidence actions they had taken to deal with the person's concerns.

On the 6 March 2018 we saw a member of staff finishing their night shift at Fairview House. We were aware the staff member had been suspended from all duties following our inspection at one of the provider's sister services on 5 and 7 February 2018 following observations of unsafe moving and handling practice. The provider had assured us the staff member would be required to complete refresher training before being permitted to work further shifts. When we discussed this with the home manager at Fairview House, they informed us they were unaware that the staff member had been suspended from duty and, on checking, found the member of staff had not completed the requisite training. This meant the provider had failed to ensure people at Fairview House were protected from the risk of receiving improper treatment by staff who are not competent in moving and handling practices.

During our inspection we saw a document which recorded concerns from a health and social care professional who had observed a person with a plate of food in their bed, clearly having difficulty in eating independently. In response to the visit the home manager agreed staff would check on the person during mealtimes and their care plan would be amended to reflect this. During our inspection we observed the person lying down in their bed, eating their meal with their fingers. There was no staff presence. Furthermore, the residents profile document which staff, particularly new staff, placed reliance on for obtaining the needs of people, had not been updated to reflect this change in need. This meant the person was continuing to be placed at risk of choking.

The above examples demonstrated a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff which the provider had deemed safe to work with them. Appropriate checks had been carried out prior to staff working at the service such as identity checks, employment histories and checks with the Disclosure and Barring Service (DBS).

Inadequate

Our findings

At our previous inspection we found significant improvements were required to ensure staff were provided with the skills, support and knowledge they needed to provide good quality care to people. At this inspection we found some improvements had been made. Staff had completed the provider's mandatory training; however we were unable to determine what specialist training staff had completed so as to enable them to have the knowledge and skills to meet people's individual needs effectively and safely. For example, two people were either diagnosed with epilepsy, or were suspected of living with epilepsy. None of the staff files which we reviewed contained evidence of staff having received epilepsy training. This also included diabetes training; at the time of our inspection seven people had diagnoses of diabetes. For people with diabetes there was no evidence to demonstrate the provider followed best practice guidance. Good practice guidelines for diabetes management in care homes recommends screening people for diabetes on admission; having a fully stocked hypoglycaemia kit and a risk assessment tool for diabetes foot disease in place and providing good quality diabetes education and training for care staff. We found no evidence to demonstrate these recommendations were in place. A request was made on 5 March 2018, and again on the 8 March 2018, for an up to date training matrix, which showed staff training for all staff working at Fairview House, including specialist training. The managing director assured us this information would be provided to the Commission on 9 March 2018. At the time of writing this report, this information had not been received.

The home manager had recently started to carry out supervisions and appraisals for staff. One member of staff told us that the supervision process had improved and was now more regular and they felt well supported. It was unclear as to what supervision had taken place since our last inspection until the home manager started work at the service. For example, records for one member of staff showed they had received supervision on 30 September 2017. There was no evidence of formal supervision after September 2017 until 1 March 2018. Supervision records for another staff member showed they had received supervision on 26 October 2017. No further supervisions or face-to-face support had been recorded until 14 February 2018. A member of staff who had started work at the service on 8 January 2018, showed their induction checklist had not been fully completed and they had received no supervision or face-to-face support. Overall, we found staff supervision was infrequent and not in line with the provider's Supervision Policy which states, 'Each supervision session should take place every six to eight weeks.' The managing director explained staff supervision had slipped as there had been a series of management changes within the service. The home manager informed us their priority since starting work at Fairview House was to review and update people's care plans. They went on to say staff supervisions would be taking place on a regular basis. As part of the supervision process they would be rolling out a 'Key worker guidance and

information pack' to all staff to enable them to fully understand their roles and responsibilities.

This demonstrated an on-going breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS). The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received MCA and DoLS training. However, on reviewing one person's care records we found MCA assessments had not always been reviewed and updated. We found some MCA assessments had been a 'tick box' exercise, and the assessment lacked information to evidence who had been involved in the decision making process. For example, the MCA had been completed by one member of staff. No one else, such as relatives and external professionals, had been involved in the assessment process which stated the person had a Lasting Power of Attorney appointed. The home manager confirmed to us there was no Power of Attorney arrangements in place for this person. The home manager informed us the MCA assessments for people living at Fairview House had not been completed accurately. They went on to say they were in the process of introducing the local authority's new MCA documentation, but were awaiting support from health care professionals to ensure they fully understood what was required to complete the documentation correctly. This meant we could not be assured that people's capacity to make decisions were being appropriately assessed, recorded and monitored and their rights promoted and respected.

However, where people had been deprived of their liberty appropriate applications had been made to the local authority for a DoLS authorisation. The home manager understood when DoLS applications were required to be made.

This demonstrated an on-going breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutrition and hydration play an important role in preserving tissue viability and in supporting tissue repair for pressure ulcer healing. As people age their skin integrity deteriorates and this increases their risk of developing pressure areas. Reduced mobility and the risks of being in the same position for long periods of time can also add to the reasons for skin breakdown.

The service was supporting a number of people who had been identified as being at risk of pressure ulcers and requiring regular repositioning. At our last inspection in July 2017, training records had shown that all 28 care staff did not have up to date pressure ulcer prevention training. At this inspection we found staff had received pressure ulcer management training however we continued to find gaps in people's repositioning charts. For example, one person's repositioning chart dated 4 March 2018 had not recorded any repositioning taking place from 13:30 to 18:00. The last recording had been at 13:30 which stated the person was on their back. The next recorded entry was at 19:00 where it was stated they remained on their back.

The person's care plan did not record how often they required repositioning, however their repositioning chart dated the 4 March 2018 recorded they required repositioning every two hours. We saw on a repositioning chart for another person that on the 4 March 2018, repositioning entries had been recorded at 01:00, 03:00, 05:00 and 07:00. There had been no further entries until 21:30.

We found there was a continued lack of robust monitoring of people's fluid intake to maintain their health and wellbeing. The systems in place to oversee this area of care delivery did not work effectively as staff were either unaware of the risks, did not take time to record and monitor or escalate concerns. Moreover, the leadership was not robust enough to ensure the governance arrangements in place were working effectively. We continued to find gaps in peoples' fluid intake charts, no set daily fluid intake targets for people recorded, fluid intake not being recorded in 'real time' and totalled at the end of each day to demonstrate if this was sufficient or not. For example, the fluid intake chart dated 4 March 2018 for one person showed for the period 14:00 and 20:00, only one recording at 17:00 for 250mls. We also noted two contradictory recordings for their fluid intake for 6 March 2018. On one chart the total daily total intake was recorded as 1050mls. The daily fluid intake total on the other chart was recorded as 300mls. In addition one chart stated the person was asleep at 05:00 whereas on the other chart it was recorded they drank 50mls at the time they had been recorded as sleeping. There was no evidence to demonstrate what actions had been taken by the service, to ensure that sufficient fluid intake was being encouraged. We could not be assured people's fluid intake was being recorded accurately and monitored effectively.

We found contradictory information regarding one person's nutritional and dietary needs. On their nutritional assessment dated 21 August 2017 it was recorded they required a soft diet. On another document which provided a summary of the person's care requirements it was not recorded they required a soft diet, nor did the resident profile document which is provided to staff and highlights important information about people's care needs. We noted the outcome of the assessment showed the person was at high risk of being malnourished. The nutritional assessment was due to be reviewed in September 2017 and we found no evidence this had been completed or that recommended actions from the assessment such as referring to healthcare professionals had been completed.

On reviewing weight records for the months of January and February 2018, we noted four people had lost more than 2.9kg in weight and one person had lost 18.2kg. On further discussion with the home manager, they were unsure whether these, and previous weight records for people living at Fairview House were accurately correct. They explained a new weighing machine was to be used from March 2018. Notwithstanding this, there was no evidence to the demonstrate actions taken by the service following these weight losses.

The above examples showed a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the mealtime experience of people living at Fairview House. There were no pictorial menus and staff were not observed showing 'plated up meals' to help people who were living with dementia, to make an informed choice at mealtimes. We also observed a member of staff providing one person with a plate of sandwiches for their tea. The person became very animated, saying, "Why have you brought me sandwiches? I hate sandwiches." The person's relative told the member of staff, "[Name] never has sandwiches. Could they have something else?" The member of staff offered some chicken soup, to which the person responded, "Yes, that would be nice, but please make sure it's hot. I cannot bear cold soup; I often have to leave it." This showed us staff were unaware of the person's dietary preferences. Observations by the inspection team throughout our inspection found staff were task focussed during mealtimes. For example, on the first floor staff were concentrating on bringing meals up from the kitchen in the absence of a working

passenger lift. This meant they were not always giving their full attention to the people they were supporting.

We received variable feedback about the quality of the meals provided. Comments included, "Food's pretty good, depends who is cooking on the day. If I didn't like the choices on offer they'd probably offer me something else like fish fingers if they had any." They went on to say, "The chips are always hard though, they're not good." Another person said, "The food is good here, they do a lovely roast. I have toast and marmalade for breakfast as I don't like cereals."

There had been limited improvements to the internal and external environment. At the time of our visit, the second floor of the building was closed for refurbishment. Some redecoration had been made to areas of the home, however the environment continued to look tired and worn. We were informed by the provider that new furniture and furnishings would be sourced for the second floor and further refurbishment would be undertaken to all other areas of the home. There was no refurbishment plan in place or evidence to show that consideration was being given to a dementia friendly environment.

People did not always have access to hot water. Although water temperature checks had been completed, we found the hot water in nine people's rooms to be cold or lukewarm. One person told us they had complained many times and told us, "but what other options do I have". Another person told us they were unable to shave due to the temperature of the water. Staff told us there was 'a knack' of being able to get hot water and described how the cold taps had to be turned on in order to get hot water. It is unacceptable for people not to have access to hot water in their rooms. We shared our findings with the home manager.

At our inspection in March 2016 a dementia specialist adviser had provided advice and recommendations to the provider on how to improve the internal and external environment at Fairview House. Although this feedback was provided, we found a noticeable lack of attention to the environment which meant it did not best assist people living with dementia. For example, there was a lack of appropriate signage, suitable colour schemes to identify types and function of rooms and the lighting in communal areas was in need of improvement as the lighting level was found to be variable within the same room/area.

People were supported to access health care services. One person told us, "I recently had a bad bout of a chesty cough. The GP came and I ended up in hospital. I didn't want to go but they [staff] talked to me about it first and explained everything." Another said, "They explain to me what my tablets are for, they listen to me and would notice if I was unwell, I think." A relative told us, "[Name] had [ailment] the week before last; they picked it up and got it treated." However, one person told us, "My heel is very painful at the moment, but they're not really listening to me, or taking it seriously." Another person said, "I've an ingrowing toenail and a bunion so I need to see a chiropodist, but I don't know when I will see one. They know about my feet, I keep telling them." A healthcare professional told us, "I have found Fairview staff to be responsive and caring to their clients in all my dealings there and have never felt concern about the care of the patients I had visited or doubt that my recommendation would be followed."

Requires Improvement

Our findings

Although, we observed staff interacting with people in a compassionate and kind way, they were often task focussed. One person told us, "Staff get stressed because they're so busy. It's not their fault." Our observations showed that although some staff were very caring, staff practice did not always ensure people were treated in a respectful manner. For example, some carers were observed not taking an engaging and communicative approach and moved around the home in a purposeful manner, moving through areas where people were seated without communication or eye contact. This presented a distinct variation of approach by staff which manifested as inconsistent and variable levels of support. Although most staff were caring, the provider did not have a caring approach because they did not ensure staff had the time and information they required to provide person centred care and support.

The majority of people's care plans were not up to date. Furthermore, not all staff had read people's care plans and there was heavy reliance, particularly by new staff, on the service's resident profile document which provided a brief synopsis of people's care needs. This meant staff, including new and agency staff, may not have important information to enable them to know about the people they were supporting.

People were not always supported to maintain their personal appearance to ensure their self-esteem and sense of self-worth. A relative told us, "[Name] always looks clean and smart, though their clothes don't always match very well." When speaking with some people we noticed their fingernails were quite long, or they had been polished sometime previously and the nail polish was now chipped and worn. One relative told us, "I mentioned on Saturday that [name] had very jagged fingernails, but they've not been done since." When we checked the person's fingernails, we noted two fingernails had broken and were very sharp, meaning they could easily scratch themselves or others.

The above examples showed a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us staff were caring and kind. One person said, "Staff make me feel good, I feel quite confident with them. Most of the staff seem to know me quite well, it's almost like they're friends now." Another person said, "Staff are very kind and caring, they look after us very well." A relative told us, "The staff here are fantastic, they really care."

People were supported to maintain relationships with friends and families. Relatives and visitors felt welcomed when they visited the service and confirmed there were no restrictions when they could visit.

The service had information on advocacy services. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves. At the time of our inspection one person was being supported to access an advocate.

People's personal records were stored securely when not in use. This meant people's information was protected to ensure confidentiality.

Inadequate

Our findings

At our previous inspection in July 2017, we found not all people living at Fairview House had an up to date care plan, which detailed their care and support needs. We also found that significant improvements were required to ensure meaningful activities were provided to enable people to engage in activities and pastimes, which interested them.

We continued to find care plans not reflecting peoples' current care and support needs. The home manager who started work at the service in January 2018 informed us they had reviewed and updated 13 out of 39 care plans, and had a deadline to complete all peoples' care plans by 1 April 2018. This meant there had been continual failure by the provider to ensure appropriate and timely action was taken following our inspection in July 2017, to ensure people's care plans and associated risk assessments were up to date. Furthermore, where care plans had been updated, there was no evidence to demonstrate involvement of people living at Fairview House and significant others in the development of their care plans. Some staff told us they had not read people's care plans, including any associated risk assessments and said they relied on the information contained within the service's resident profile document. This document was provided to all care staff. The purpose of the document was to provide staff with a brief overview of peoples' social/health problems, medication, daily care required and specific care requirements. We were further informed the resident profile document was updated on a monthly basis or as and when peoples' needs changed. On review of the resident profile document, we found it did not reflect the current care and support needs for all people living at Fairview House. For example, one person's needs had changed significantly following their discharge from hospital on the 27 February 2018. They were receiving end of life care, however this information was not recorded on the residents profile document. One member of staff we spoke with was completely unaware people had a care plan and informed inspectors they take all information from the resident profile document, or from other care staff to enable them to provide care and support to people. When we asked the staff member where they would find guidance to support a person who required hoisting, such as the type of sling/straps to be used to ensure safe transfer, they informed us they did not know.

We found care plans to be inconsistent and records of care such as fluid intake and repositioning charts poorly completed. This meant we were not assured that people had received care in line with their needs. Some care plans contained insufficient guidance for staff on how to support people with specific health conditions such as catheter care and epilepsy. For example, one person's catheter care plan was not within their hard copy care plan. The home manager confirmed to us a catheter care plan was saved on the provider's electronic version care planning system. The service ceased using the electronic care planning

system in December 2017 and new staff were unable to access electronic care planning records.

At this inspection the service could not demonstrate how they ensured people received personalised care, which was responsive to their needs. Care plans, as highlighted in other sections of this report, had not been appropriately reviewed and updated. This meant there was a risk that people's preferences, interests and aspirations were not known by the care staff supporting them and would mean people received inappropriate care and support. For example, one person we spoke with had a keen interest in golf. Their care plan made no reference to this. The person told us that staff had told them they would arrange a golf related activity. They went on to say they would like to visit the clubhouse of their old golf club for a drink. This had not been actioned. On review of the person's care plan we noted several sections of their care plan had not been completed, such as their family history profile and a 'This is me' document. There were risk assessments in place for the person however none were in relation to social and leisure interests. This meant their care plan was not reflective of a person centred approach. One member of staff who had worked at the service for a long time demonstrated an understanding of people's needs but informed us this was based upon developing relationships with people rather than reading people's care planning documentation.

Following our last inspection, we placed a restriction on the provider's registration to not admit any new people to Fairview House without the prior written agreement of the Commission. On the 6 February 2018, we received a request from the local authority to admit a person who had previously lived at Fairview House. We agreed to this request as it was deemed in the person's best interest. We requested a copy of the person's pre-admission assessment and care plan to be forwarded to the Commission by 9 February 2018. The provider forwarded the pre admission assessment; however we had to chase for the care plan, which was duly received on the 13 February 2018. The care plan submitted on the 13 February 2018 was a copy of the person's original care plan dated 26 October 2017. This care plan had not been reviewed and updated following the person's discharge from hospital and re-admission into the service. During our inspection we noted the person's care plan had still not been updated. Whilst the home manager informed us the person's needs had not changed, the lack of an updated plan of care with associated risk assessments after a discharge from hospital placed the person at risk of receiving unsafe care and treatment as staff would not know if any of their needs had changed. The managing director informed us care plans should be reviewed and updated within 48 hours following a person's discharge from hospital.

During our inspection, we were informed one person was receiving end of life care following their discharge from hospital in February 2018. Their care plan had not been reviewed and updated to reflect changes in the delivery of their care to ensure they received dignified and comfortable end of life care. The resident profile document shared with staff had also not been updated to reflect the person was on end of life care.

The home manager informed us that once all the care plans had been reviewed and updated, senior staff will be responsible to ensure they are kept updated and reflective of people's current care and support needs. They went on to say they would be providing staff with clear guidance and will run workshops to ensure staff have a clear understanding of the care planning process and of their responsibilities.

We observed a lack of activity and stimulation being offered to people. Whilst some people showed us their daily newspaper, which they told us they enjoyed reading and completing the quizzes and crosswords inside them, we did not observe any person being offered any other stimulation. We spoke with one person who, at the end of our conversation, thanked us; they said, "Thank you so much for spending time with me, it's been so nice". Another person said, "I'd like more things going on, somebody has read the paper to me before but I'd like a bit more time spent with me; they're [staff] just too busy to chat." One person told us how they spend all their time in bed and their television was their lifeline. They explained to us they had listened to an

audio book which they had thoroughly enjoyed. They went on to say, "My problem was that when it needed changing the staff were too busy to come and do it. I gave up in the end; it's not worth trying again even though I really enjoyed it."

There was no activities coordinator in post at the service. There had also been no activities coordinator in place at our previous inspections carried out in March and July 2017. We continued to observe people sitting in the same chair all day, many asleep and observed minimal interactions with people by staff. Whilst the home manager advised us there were resources within the service such as twiddle mitts and reminiscence boxes, these were not observed being used during the course of our inspection. Twiddle mitts are knitted mittens or hand warmers with beads, ribbons, buttons and other objects sewn onto them. The mitts support people living with dementia and provide them with objects they can hold onto and twiddle to help reduce their anxiety and promote calm. At our inspection in March 2016 a dementia specialist provided extensive feedback to the provider around the improvements required to ensure meaningful activities are provided to people living with dementia at Fairview House. These recommendations had not been acted upon and demonstrated the lack of importance the provider had placed on improving the social lives for people living with dementia at Fairview House.

The home manager informed us a new activities coordinator had been recruited and was currently going through the recruitment process. It was noted since the home manager had started work at the service several activities had taken place; for example, an Owl show, Valentines party and cheese and wine afternoons. The home manager told us they were committed to improving the activity programme at Fairview House. However, whilst some minor improvements had been made, people's social and wellbeing needs were not being met effectively.

The above examples demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection records showed two complaints had been raised in February 2018 which had been immediately addressed by the home manager.

Inadequate

Our findings

At our last inspection we found a continued failure by the provider to have robust quality assurance systems in place to effectively monitor the service so as to ensure people's safety and mitigate risks relating to their health, safety and welfare.

At this inspection, whilst some improvements had been made, the provider was continuing to fail to take the action required to improve the quality of the service. For example, making sure effective quality assurance and auditing systems or processes were in place and embedded to drive improvements and mitigate any risks relating to the health, safety and welfare of people using the service and others. The home manager told us they had recently introduced an hourly observation checklist which senior care staff completed. This included checking people's rooms, fluid intake and repositioning charts. However, the home manager advised the observation checklist was not always being completed. On checking the document, it was unclear what was actually looked at as part of the checks. It was evident thorough checks of peoples' rooms were not being undertaken, placing them at potential risk of harm.

Despite assurances from the provider following our last inspection and the conditions imposed by the Commission on their registration, the lack of governance and managerial oversight has led to continued failures in multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we spoke with the managing director on the 8 March 2018, they told us they were 'gutted' improvements had not been made. No rationale was provided for the provider's lack of oversight. This clearly demonstrated a lack of governance and scrutiny by the provider. One person told us, "I think the big bosses should be forced to live here for a fortnight, and then I guarantee they'd run back to their offices and change things for us."

The poor oversight and absence of leadership has resulted in a lack of structure and direction for the staff team. Staff were unclear on their roles and responsibilities and had not been provided with appropriate training or guidance to enable them to effectively carry out their role. Staff had not received regular supervision since our previous inspection and, although the home manager assured us they were going to ensure staff received regular supervision going forward, this meant staff had not had the opportunity to receive regular structured supervision to enable them to discuss work related matters including their training and development.

Furthermore, the provider had not been proactive following our last inspection to ensure people's care plans were reflective of their current and support needs. This meant staff may not recognise or manage risks

accordingly or provide care and support in relation to people's preferences and needs. Examples of what this meant for people living at Fairview House can be found within the Safe, Effective, Caring and Responsive sections of this report.

We discussed our concerns with the managing director who acknowledged the service should be more effective at monitoring the delivery of care to people living at Fairview House. They went on to say, "The biggest failure is the updating of records." This clearly demonstrated the provider had consistently failed to ensure people in their care receive care in line with their needs, and were protected from unsafe care and treatment, including identifying potential risks and taking action to reduce these risks. Moreover, the home manager had not received a formal handover, induction or supervision since starting work at Fairview House and despite the service having a quality rating of 'Inadequate' and being placed in 'Special Measures'. The home manager had several action plans in place and it was not clear how these were being effectively actioned, managed and monitored by the provider.

Following our previous inspection, we shared our concerns with the local authority. Since December 2017 the provider had attended monthly meetings with the local authority to discuss on-going work to improve the service. The Commission also attended these meetings. However, despite support by the local authority, the provider has been unable to drive, embed and sustain improvement. The outcome of a quality monitoring visit by the local authority in January 2018 found the service at Fairview House to have an overall rating of 'Poor'. For example, they found a lack of evidence that people's needs, together with any risks to their health and well-being had been taken into account in the planned delivery of people's care. They found similar issues to those we have identified during our inspection such out of date care plans, the times people required repositioning were not recorded and a thorough analysis of falls was not undertaken.

The provider appointed an external consultant in January 2018 to support improvements at Fairview House. The managing director informed us external consultancy had been brought in to gain oversight of the service and, if any issues are identified, they would support the home manager to develop an action plan. We saw an action plan had been developed following the consultant's visits. We noted there were no set timescales for when the actions should be completed, the action plan purely stated whether the actions were a priority or not. Whilst some actions had been marked as completed and on-going, such as the checking and recording of daily checks of the environment, ensuring creams were not being left in people's rooms and checking people's fluid and repositioning charts, we found no evidence to demonstrate these had been undertaken.

We could not determine how the service was continuously learning, improving and ensuring sustainability, as the concerns we had identified at our previous inspection had not been addressed.
The systems in place to learn from accidents and incidents were not always effective as these had not been thoroughly analysed to identify trends or concerns, and enabling appropriate measures to be put in place to mitigate reoccurrence This included robust examination of witnessed and unwitnessed falls and safeguarding incidents. This meant the provider was not learning from incidents and taking appropriate action to ensure people's health, safety and wellbeing. Medication management and monitoring had also not identified the issues we found with regards to omissions in topical cream charts and ensuring a competent trained member of staff was available at all times to administer medicines if required.

The above demonstrated a continued failure of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No surveys had been carried out since our last inspection. The home manager informed us questionnaires had recently been sent out to relatives and the responses would be analysed once the responses had been

received. Relatives confirmed they had received the questionnaire. One relative told us, "I hope that they really want to know what we think and it's not just a tick box thing. I'd like to think they'll change things afterwards." Another relative said, "We've never had a questionnaire before, but I'm not convinced they'll do anything as a result." This suggested that people's relatives were not confident of the provider's ability to make the required improvements and listen to what they had to say.

There had been a series of management changes at Fairview House. People spoke positively about the home manager and told us they were more 'hands on' than previous managers. One person told us, "I don't think there's anything which can be improved here, I'm more than satisfied." A relative told us, "[Name of manager] has been feeding people today, that's not for your benefit, [name] does that quite regularly to help out the staff." They went on to say, "The new manager is fantastic, they are on the side of residents and relatives. They are approachable and work hard. [Manager] was here all night recently because they were needed." A health care professional told us, "I have had dealings with the new home manager while they were at [name of service] for a couple of years and have found [manager] to be professional and caring at all times. Having good knowledge of the residents and supportive to staff." A member of staff told us they felt supported by the home manager. They said, "It's better here than before but there's still things to be done such as staffing levels, care planning and décor."

The ratings from our previous inspection were displayed in the entrance of the home and on the provider's website. The display of ratings is required by us to ensure the provider is open and transparent with people who use the service, their relatives and visitors to the home.