Fairfield House Healthcare Limited

Fairfield House Residential Care Home

Inspection report

Fairfield House
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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

The inspection took place on the 27 September and 4 October 2016 and was unannounced. We last inspected the service on the 21 July 2014 and found regulations were met.

Fairfield House Residential Care Home (known locally as "Fairfield House") provides residential care for up to 36 older people who may have a physical disability or be living with dementia. There are 33 rooms and 33 people were living at the service when we visited. Nursing services are provided from the community nursing service.

A registered manager was employed to manage the service. 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.

We found the staffing of the service did not always meet the needs of people living at the service. Staffing of the service was raised as a concern from people and the district nurse on the first day of the inspection. In particular, staff needed to understand and meet people's increased or increasing needs. We found staff were working long hours across the week to meet people's needs. This included the registered manager and other members of the senior management team. This meant the contingency to meet unexpected staff short falls was in operation every day and had become the norm. Staff did not have time to spend with people to ensure their emotional and social needs were met. We have recommended the provider and registered manager review staffing to ensure there are enough staff to meet needs as they change.

Staff were task focused. When staff were involved in a task, staff treated people with politeness, kindness and were considerate of people's needs. People's emotional and social needs were not always being met.

Staff were recruited safely to ensure they were suitable to work with vulnerable people. People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff stated they would pass on any concerns to the registered manager. All staff felt action would be taken in respect of their concerns. Staff said they would raise their concerns with external agencies, such as CQC, if they felt concerns were not being addressed. Records showed safeguarding concerns had been fully investigated and action taken as required.

We found staff received training, supervision and appraisals to support them to care for people. However, this had been impacted on by the staffing issues. This meant training of some staff had been delayed, although it was still taking place. The tracker showed gaps in staff training in both mandatory subjects, as identified by the provider, and in areas that would have addressed the wider needs people had. Also, training for staff in respect of dementia care needed updating and was not offered to all staff despite having a high number of people living with dementia. Plans were in place to ensure all staff were trained in these areas.

People were not being assessed in line with the principles of the Mental Capacity Act 2005 (MCA). Requests for authorisations to deprive 15 people of their liberty had been requested without first completing an assessment of the person's capacity to consent to their own care and treatment. This meant the legality of how people were being assessed and deprived of their liberty could not be assured. Also, decisions in relation to people's care were being made without assessing whether the person had the capacity to consent, or whether they required a best interest decision to be made. When offering care people confirmed staff always asked their consent and staff understood the importance of seeking consent on each occasion. The registered manager had started to address this by the second day of the inspection for one person.

People's nutritional and hydration needs were not always met. On the first day we found two people had lost weight. Where advice had been taken from health professionals this was not always followed, sustained or further support requested if needed. Also, tracking of people's food and fluid intake was not always in place. People's health needs were not always met when needed. People could see their GP or district nurse and a range of other health professionals. However, the timeliness of some referrals meant some needs were not being met promptly. For example, a Grade 2 pressure sore was noted on one person's sacrum when the district nurse was asked by the GP to address another health issue. Referrals were made to occupational therapy, CPNs and other services without involving or informing the GP or District Nurse to ensure consistency of care and treatment. Communication issues within the service meant that the registered manager, deputy manager and care lead did not always know of the referral or why it had been made. This meant consistency of care and treatment was not always being achieved for people. New systems for meeting people's needs were being introduced by the end of the inspection.

People spoke positively about the food with choice available. People could contribute ideas to the menu and have alternative choices, if preferred.

People were not always assessed to ensure care was personalised, appropriate and met their needs. Care plans were in place however, generalised statements that were on all care plans meant staff responses to people's needs were not personalised. Significant areas of need were not addressed within the care plans to ensure staff had the right guidance to meet people's needs. A "This is me" and daily routine documents were on most records however, we found key information staff would need to know was not always included. People living with dementia did not have care plans in place to meet their specific needs. For example, there was no recording of how the dementia was affecting them at that time and the role staff could take to meet their needs. We found key risk indicators, in terms of dementia, were not evident. Some people were recorded as having behaviour management challenges for staff, and one person constantly wished to leave. We found that these people's records did not evidence any risk management or mitigation. Staff described how people's end of life needs were met in a personalised way, however people were not involved with planning them.

Activities were provided but did not reflect the needs of people living with dementia. There were 20 people identified as living with dementia at the service but there were no clear plans in place for meeting their social needs through activities. The religious and social needs of people without dementia were met. People could maintain contact within the community or their own church or club.

People had risk assessments in place to keep them safe whilst living at the service. These were being reviewed to ensure all areas of personal risk were identified and assessed. Also, work was taking place to ensure these were linked to people's care plans. People had plans in place to help keep them safe if there was an emergency such as a fire.

People's medicines were generally managed safely. We identified some practice issues for the registered

manager to address. People's prescribed creams were accounted for and clearly recorded.

The registered manager had a range of audits in place. The provider had employed the services of a consultant to audit the service. They also had regular contact with the registered manager. However, this had not identified and prevented the concerns being raised in respect of the inspection. The roles of the registered manager and other members of the senior management team were not defined enough to ensure the service was well-led at the local level. For example, there was duplication of roles and an assumption some tasks were being done by another team member.

Staff, people and visitors felt the registered manager was approachable. People were asked their view about the service and how it was run. Action was taken to address any suggestions.

People's concerns and complaints were acknowledged and investigated. People said they knew how to raise a complaint and felt comfortable speaking to the registered manager. A complaints policy was in place and made available to people and relatives.

Staff followed safe infection control practices. We identified one person's bed room smelt of urine. Action was taken to ensure this was addressed.

We found breaches of the regulations. We have advised the local authority of our concerns. A safeguarding meeting was held by the local authority to review the concerns and recommendations made on reviewing aspects of the service. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Concerns were raised about staff numbers. We have recommended the provider and registered manager review staffing to ensure there are enough staff to meet needs as they change.

Risk assessments were in place but were being reviewed to ensure all needs were risk assessed as required.

People's medicines were generally managed safely with some minor practice issues addressed during the inspection.

People were supported by staff who understood how to identify and report abuse.

Staff followed safe infection control procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not assessed in line with the Mental Capacity Act 2005 as required. Authorisations to deprive people of their liberty were sought without staff first assessing their capacity. Decisions were being made about people's care without ensuring this was in the person's best interests.

People's needs were not being routinely reviewed if they lost weight. Where assessments were taking place the follow on care was not always consistent.

Staff were trained to meet people's needs. Staff training was not always refreshed or updated due to staffing levels.

People saw health professionals when needed, however the involvement of professionals was not always well co-ordinated to ensure good communication and consistency.

People told us they liked the food and were offered alternatives.

Is the service caring?

Requires Improvement

The service was not always caring. Staff were task focused. When staff were involved in a task they treated people with politeness and kindness and were considerate of people's needs.

People's emotional and social needs were not always being met.

People's end of life was not planned with them. Staff told us people's end of life needs were met in a personalised way.

People spoke positively about the staff but felt they were not always able to spend time with them.

Is the service responsive?

Requires Improvement

The service was always not always responsive.

People's care plans were not always personalised. Significant needs were not being planned in a way that would meet that person's individual needs.

Activities were provided for people to take part in. Specific plans were not in place to meet the needs of people living with dementia.

People's faith needs were met.

People's concerns and complaints were acknowledged and investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems of quality assurance and audits had not identified the concerns raised during the inspection.

The roles of the registered manager and other members of the senior management team were not defined sufficiently to ensure the service was well-led at the local level.

People, families and staff spoke highly of the registered manager and felt they were approachable. They were consulted with regarding their view of the service.

The registered manager had systems in place to ensure the building and equipment were safely maintained.

Fairfield House Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 27 September and 4 October 2016 and was unannounced.

The inspection was completed by two inspectors and a specialist nurse advisor who specialised in the care of people living with dementia, mental health and the Mental Capacity Act 2005 (MCA).

Prior to the inspection, we reviewed our records of the service. This included notifications. Notifications are specific incidences registered people are required by law to tell us about. We also reviewed the Provider Information Record (PIR) sent to us by the registered manager. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people and two visitors. We reviewed the care of six people in detail, checking they were receiving their care as planned. We checked six medicine administration records and recording of how staff accounted for applying people's prescribed creams. We spoke with them to check how the staff were meeting their needs. We also sat with people at lunch and spoke with them. We observed how staff and people interacted with each other.

We reviewed three staff personnel records, staff training records and spoke with six staff. We were supported on the inspection by the registered manager and deputy manager. We had email communication with a director who was also the nominated individual (NI) who was able to answer questions at the provider level. We reviewed information held by the registered manager which they used to check the quality of the service.

We also reviewed maintenance records and systems in place to make sure the equipment and building were safe. We spoke with one health professional during the inspection.

Requires Improvement

Is the service safe?

Our findings

Staffing of the service was raised as a concern from people and the district nurse on the first day of the inspection. The concern raised related to whether there were enough staff who were suitably qualified, competent, skilled and experienced to meet the needs of people living at the service. This was due to the numbers of people living with dementia at the service and requiring staff to understand and meet their increased or increasing needs.

We asked the registered manager how they knew the number of staff required to meet people's needs safely. They advised the consultant employed by the provider had given them a way of looking at how dependent people were on staff, but found this unhelpful as it did not calculate hours or numbers of staff required. In order to judge the number of staff, they looked at feedback they received from staff, people and their own observations. The registered manager advised they had trouble recruiting staff, had recruited staff who were unsuitable who then had to be dismissed and staff had left because the needs of people living at the service had increased to a level that they were unable to cope with. This meant some staff, including themselves, the deputy manager and care lead, had needed to work excessive hours to fill the gaps in the rota in order to provide care. This also meant the contingency to meet unexpected staff short falls was in operation every day and had become the norm.

We reviewed the staff rotas and saw there were times, when there would not be enough staff to meet people's needs. This was a particular concern at weekends when medicines were being administered. Staff, with care responsibilities, were also seen to be working long hours (recorded at 50 to 78 hours a week) in the last six weeks.

People told us there was no time for staff to sit and talk to them. Staff told us they had little time to ask people how they were as they needed to move onto the next person in order to meet everyone's needs in a reasonable time frame. Staff told us staff from the day shifts had been moved to cover night shift as night staff had left. This left the day times short of staff. Staff and the registered manager told us people's needs at night had become higher and two staff were unable to manage. The registered manager had responded to this by seeking to use three members of staff during night shifts however, these were only going to come from the existing staff team.

We discussed with the registered manager how this was impacting on people and how people's needs were being missed or not followed up. The risks had increased or were increasing for people as staff were tired and being affected by the hours they were working. We talked about the range of people not being picked up or their care needs not being met. For example, a person with continence needs who was living in a bedroom smelling of urine and a person who we saw who was emotionally distressed on both days who staff were not picking up on. Staff had stopped seeking other ways to meet these needs.

We also talked about how staff training had been postponed around the needs to staff the service safely. One staff member told us how people's baths were postponed from the morning if they did not have enough staff adding, however they would attempt to fit them in the evening.

One staff member said, "We recently had not enough staff, but it's creeping up now" adding, "Staff are tired having covered extra shifts. The energy has been lost and this has an impact on people." Another said, "The staff are working hard. There are not enough staff to have time for one to one as you are rushing in and out" adding, "Staff are working so many hours with some working over 70 hours a week."

We recommend the provider and registered manager review staffing to ensure there are enough staff to meet people's needs as they change.

The registered manager advised they were constantly advertising for staff but applications were minimal.

Staff were recruited safely. The registered manager ensured staff had the necessary checks in place to work with vulnerable people before new staff started in their role. All prospective staff completed an application and interview process.

People's medicines were administered by staff trained to complete this task. Medicine administration records (MARs) were completed fully however, we noted there was no system to ensure people had the correct gap between their prescribed medicines at all times. Staff noted the times when 'as required' medicine was given however one person had been given a medicine requiring at least a four hour gap at 10am and 1pm. The MARs showed another person had received their pain relief medicine for seven out of 24 doses over a six day period. The person was described as "asleep" for several doses with no evidence this had been followed up with the GP. For some of the days, the MAR recorded the medicine was "out of stock" with again no evidence this had been reordered promptly once it was realised the medicine was not available.

A number of people were taking 'as required' pain relief medicine on each occasion. The GP had not been requested to review this to see if this needed to be prescribed or there was an escalation in the person's pain. One person was taking a herbal remedy alongside their prescribed medicine which had not been checked with the GP to make sure the different medicines did not affect each other.

We discussed the above issues with the registered manager. The administration of medicines was audited at regular intervals. The registered manager and deputy manager immediately looked at ways to complete further checks and address the concerns raised and put things right.

Medicines were stored safely. Everyone we spoke with told us their medicines were administered on time and as they would like. People were not rushed to take their medicines. Staff ensured people were given their correct medicine and observed the person taking their medicine before recording this on the MARs. Staff checked at the end of each medicine round each person had been given their medicines. People who required their medicine every 12 hours as they were diagnosed with Parkinson's disease received their medicine as required.

People's prescribed creams and topical medicines were clearly recorded. Staff were given precise details of where on the body each cream should be placed and in what quantity. Body maps were used to facilitate this. Staff clearly recorded the use of creams. People we spoke with felt staff made sure they had the right cream applied as needed.

Risk assessments for some risks were in place to support people to live safely at the service. However, not all risks assessments were clearly linked to people's care plans or followed up on. For example, when someone was at risk of malnutrition. Also, risks around issues that were specific to that person were not being recorded and reviewed. For example, risks of choking and for those with diabetes. Risks were also not telling

the registered manager if there was an issue with staff numbers and staff training. The registered manager, deputy manager and care lead looked at ways to start addressing this during the inspection. They advised they were aware they needed to put individual risks assessments in place for some issues, such as people using warfarin, and would review all people so they had the appropriate risk assessments in place.

We reviewed infection control practices as one person was living in a room was malodorous. We found the room had been cleaned however, action had not been taken to address the furniture and fittings which continued to smell. This was addressed by the second day and a new carpet and mattress had been ordered. A family member told us they cleaned their relative's room as it had not been kept clean by staff at the service. They advised they had found faeces on the wall and bedding. We informed the registered manager of this who agreed to ensure this was addressed. Staff used aprons and gloves when delivering personal care. There were appropriate systems in the laundry to manage contaminated washing. Staff were suitably trained and an infection control audit was completed.

Personal emergency evacuation plans (PEEPs) were in place to ensure people were kept safe in the event of a fire or other emergency.

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff stated they would pass on any concerns to the registered manager. All staff felt action would be taken in respect of their concerns. Staff said they would raise their concerns to external agencies, such as CQC, if they felt concerns were not being addressed. Records showed safeguarding concerns had been fully investigated and action taken as required.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

People were not being assessed in line with the MCA as required. 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. None of the records held an assessment of people's capacity. The registered manager advised it was at least five years since MCA assessments had been completed. This was despite 20 people being identified as living with dementia, Parkinson's and short term memory loss that meant they were likely to have limited capacity or to lack capacity to make decisions about their care or treatment.

Where people were likely to have reduced ability to make decisions, records made generalised statements about their ability to choose aspects of their care. With the absence of the MCA assessment it was not possible to review how the decisions had been reached. No decisions about how staff were meeting people's care needs evidenced if this was in the person's best interest. One person we highlighted with the district nurse during the inspection due to their continence needs, highlighted that the level of cognitive functioning within the care plan was higher than that known to health professionals. This meant their continence needs were not being fully met. If the district nurse, and other professionals and those known to the person, had been involved, their continence care planning would have more than likely met their need within their best interest.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). One DoLS application had been authorised by the local authority designated officer and 15 had been applied for. The registered manager did not understand the MCA assessment needed to take place first in line with the MCA before applying for DoLS authorisation.

Not assessing people in line with the MCA and failing to ensure people's needs were being met in their best interest is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection we were advised by the registered manager they had identified how to assess people's capacity and had started the process of completing them for the one person with an authorised DoLS. Also, the deputy manager and registered manager were due to attend refresher training in respect of the MCA and DoLS on the 14 October 2016.

Staff understood the importance of asking people's consent to their care. Staff told us they would always ask if people were ready for personal care, for example. They would go away and come back if the person

declined. One member of staff said they would offer other ways of supporting the person in the morning if they went in to offer personal care for a second time and the person declined. For example, they would ask the person if they wanted to go to the toilet and back to bed. In this way, the person could rest comfortably.

People told us they could ask to see their GP as required and some people were seeing the district nurse for issues to do with their skin. People could also see an optician, dentist and podiatrist as required. The district nurse told us that in the last 12 months, staff making referrals to their service appropriately had declined. The timeliness of some referrals was also not as good as they once were. For example, a Grade 2 pressure sore was noted on one person's sacrum recently when the district nurse was asked by the GP to meet another need. The district nurse stated this should have been referred sooner. This had been referred to the local authority and reviewed under safeguarding vulnerable adults.

We also found there was no protocol for how and who to involve in making a referral for external specialist assessment and support. For example, referrals were made to occupational therapy, CPNs and other services without involving or informing the GP or District Nurse to ensure consistency of care and treatment. Communication issues within the service meant the registered manager, deputy manager and care lead did not always know of the referral or the need. This meant no one was overseeing the process to ensure the person's needs were being met. Also, advice was not readily sought when they were struggling with meeting an area of a person's care plan. For example, meeting the continence needs of a person with advanced dementia who as a result was then living in a smelly environment in their room.

Not ensuring care and treatment was appropriate and met people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about issues we were identifying about ensuring consistency of people's care and treatment on the first day of the inspection. On the second day they advised us they had discussions with the deputy manager, care lead and senior carers about ensuring communication and involving professionals already involved in people's care with the key person being people's GP. A new protocol was being developed.

People's needs in respect of meeting nutritional and hydration needs were not always met. On the first day records detailed two people had lost weight. One person had lost 20kg between January and September 2016 and another had lost 5kg between July and September 2016. Their associated care plans did not detail that action had been taken to address this or where advice had been given this had not been followed through.

For the person who had lost 20kg, care records from July 2016 stated they had reduced appetite since the end of 2015 and were at high risk of malnutrition. They had seen a dietician in April 2016 and staff were to weigh them weekly, milkshakes were to be encouraged and close monitoring was to be in place. Records did not evidence staff had followed this advice. In July 2016 records said this person had put on weight and now could be weighed monthly. Their weight had not been recorded in July 2016; the last weight recorded at the end of June noted further weight loss of 0.4kg. The Speech and Language Team (SALT) had advised their food needed to be prepared in a specific way. When we spoke with kitchen staff they were unable to locate they had this information available, but stated the food would have been prepared as required. This person was living with advanced dementia and was unable to communicate with us. We did however, speak to their relative who advised us the initial advice from the dietician was followed, but not sustained. They also told us the person had been prescribed food supplements but these too were not consistently given or were left for the person to drink without staff support. The relative added that drinks were often left for the person to drink when they needed prompting and supporting by staff. This put the person at increased risk

of dehydration.

We raised a concern with the registered manager about the two people above and staff were writing people's weights down but were not identifying or passing on any weight change concerns. We requested the registered manager review the weight records of all people from January- September 2016. This audit identified five other people who had experienced weight loss.

Two people we observed at lunch ate very little of their lunch. Staff did not ask if these people had eaten enough or would eat something else to ensure they had enough to eat. One of the people had asked for the same choice of lunch as another person at the table and when the food arrived stated it was unlikely they would have asked for this as they did not like it. This comment was not picked up on by the staff member. We advised the registered manager of our concerns that these two people may not have eaten enough.

Snacks and drinks were available in the lounge if people wanted them although we did not see anyone utilise this service. We also did not see people being reminded they were there. People who could not mobilise easily or were living with dementia would have required staff intervention and support to make use of this resource.

Not ensuring people's nutritional and hydration needs were met is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection (the following week), the registered manager advised us they had reviewed the people with weight concerns and put in place new monitoring processes. Care plans were being reviewed. They had also referred the seven people who were raising a concern to their GP. New paperwork and an audit had also been introduced to quickly identify any concerns in the future. A member of staff told us they had been advised of the concerns and their role in making sure any concerns with people's weights were alerted to the senior management team. They told us they felt the practice was safer now with a clear recording tool put in place to monitor people who were causing a concern. It was too early to judge this had met people's needs and was now ensuring people had enough to eat and drink.

People, able to communicate with us, stated they liked the food and were offered alternative choices if they did not like what was on the menu. They felt the portion sizes were adequate and they had enough to eat and drink. Staff could access snacks and drinks for people at any time if this was requested.

We found staff received training, supervisions and appraisals to support them to care for people. However, this had been impacted by the staffing issues. This meant training of some staff had been delayed rather than not taking place. Plans were in place to address gaps in the provider's mandatory training. Training in dementia care needed updating and was not offered to all staff despite having a high number of people living with dementia residing at the service.
The activity co-ordinator had received dementia training and was due to attend Parkinson's training so they could understand the specific requirements of people living with these needs.

Staff told us they felt they were well trained. They felt training was seen as important and they could make suggestions for training and this would be met. For example, a staff member had requested training in respect of anxiety and depression and that had been provided. A newer member of staff stated they had been given the Care Certificate to complete. The Care Certificate is a nationally recognised induction programme for staff new to care introduced to ensure a standard of care is provided. All staff said they had had a recent appraisal which they had found helpful to reflect on and helped identify any professional development they could undertake to improve how they worked.

Requires Improvement

Is the service caring?

Our findings

When staff were delivering a task, such as serving lunch and making sure people had their drinks as they liked them during the morning and afternoon drinks, staff were observed to be polite, kind and considerate of people's needs. However, we found staff were not always identifying people's emotional needs or their right to be in control of their care. For example, one person we spoke with had always lived independently until a swift change in their needs meant they had moved into the service. We asked how they were finding this, and they told us they were finding it "very hard". They said the staff were "very good" but when we asked if the staff had checked they had settled they told us "No". They added we were the first to ask how they were feeling in the five weeks since they moved in. They added, "I feel staff are busy with other people; people don't realise how big a step this is for me."
Also, another person told us they felt they were now considered a "tell-tale" for speaking up if they felt something was wrong about their or other's care. They said, "I am very happy here; we are well cared for" but, felt their speaking up had been a negative experience for them.

One person, who was living in a poor environment in their room which was malodourous, was described as this was "being them" as opposed to ensuring their need for good continence care and an environment free from smell was met. Also, another person was observed walking around the foyer area on both days. On the second day they were observed to be in a distressed state and staff did not find out what was wrong. We spoke with the person who told us, "I am so very lonely; I get fed up being on my own." They added, "The staff are very good; I expect they chat if they have time. The staff are certainly polite and kind".

The desire for making friendships, and the opportunity for times when people could be together to build these, was mentioned by three people. Also, one person stated there were only four men currently living at the service and they would like ways to look at how their needs could be met so they could have shared times. We observed the lounge to be full and activities did take place, but there was little conversation between people.

We spoke with the registered manager about meeting people's social and emotional needs. Also, we fed back staff had told us they had enjoyed training in depression and anxiety very recently but were not applying the learning in practice. People told us they felt staff did not have time to spend with them. The registered manager agreed to look at this with staff to identify which people wanted and needed this support.

People's end of life care was not being planned with them. Staff told us people's end of life needs were met. All staff said people would be given personalised time at their end of life. Staff would sit with people and ensure they were not on their own and had the necessary pain relief from the district nurses. One staff member described when they sat with one person and read their favourite poems to them. They had held their hand as they passed away and made sure they knew they were not alone. The registered manager advised they were seeking to attain the Gold Standard in end of life care however, there was no evidence this had progressed in respect of ensuring people's wishes and feelings were met at this time. The registered manager advised there were plans in place to address this.

People said staff always respected their privacy and dignity. During times of personal care, curtains and doors were closed. Staff knocked on doors and waited for a response before going into people's rooms. Staff greeted people by their chosen way to be addressed. One staff member said, "People are all respected; they all have dignified care. We answer all their questions or speak to someone who will have the answer." Relatives in a recent questionnaire response stated, "Dignity and Respect? Definitely, she is well understood and I feel liaison between staff is very good" and, "Yes (she is treated with dignity and respect), particularly when my mother comes down for breakfast at 4am".

People were positive about the staff. Comments we received included, "We are very well looked after; everyone is wonderfully looked after"; "Our staff are wonderful; I wouldn't change any of them. The staff are more than lovely; all the staff are always kind" and, "The staff are extremely good; very pleasant and courteous".

Staff spoke about the people they were caring for with enthusiasm and understanding. Comments from staff included, "I treat people as I would want my nan and granddad treated; everyone's lovely"; "Fairfield House has a friendly atmosphere; not as a hospital" and, "Residents are well looked after here". All the staff spoke about how they would like to do more with and for people if they had more time. One staff member said, "People are not getting enough one to one stimulation. People in their rooms, I try to go and speak to them if I have a spare minute."

Professionals who had responded to a survey sent to them were positive about the service. Comments included, "I very often hear staff talking to residents when I am working and I'm very impressed with the way they are treated"; "Staff always respond to any concerns"; "I have to say Fairfield House has a fantastic atmosphere as soon as you walk through the door" and, "I will always recommend it to my private clients in the community".

In written feedback to the service, relatives said they could come when they liked and were always greeted warmly by staff. They were then updated on their family member's condition where appropriate. Refreshments were given regardless of the time of day. Comments included, "Staff are always professionals and approachable"; "Mum feels that staff cannot do enough to help her here. She feels very cared for": "Fairfield House is an amazing place with outstanding staff"; "We are very, very happy with the care my father receives" and, "Staff are polite cheerful, helpful; excellent ambience always".

Requires Improvement

Is the service responsive?

Our findings

Care plans were in place however, people we spoke with could not recall being involved in their development. People's care plans did not always evidence involvement by people or their representative. We found people's care plans had some information which was personalised but also information was exactly the same as in other people's care plans where records had been copied. Staff were therefore, not being providing with the individual way that person would like their needs met.

Significant areas of need were not covered to ensure staff had the right advice to meet people's needs. Looking at a personal history had not been completed for all people which meant staff did not always have these details in order to deliver personalised care. A "This is me" and daily routine documents were on most records however, we found key information staff would need to know was not always included. For example, two people requiring clear continence care plans did not have this information included in either of these documents. This meant staff did not have the preferred routine for these people in order to meet this need. The care plans for people's continence needs were again non-specific and often included generalised statements, such as protecting their dignity and having plenty of toilet rolls available, rather than how to meet this need for that person in respect of a preferred routine for going to the toilet. Also, one person was diagnosed with a health condition relating to their kidney function dating back to 2006 which may have impacted on their current continence needs. This was in the information provided from the GP, but had not been picked up in their care plan. Further questions were not asked of the GP as to whether this needed to be included in information to the continence nurse or to staff, via the care plan, to ensure all needs were included in the assessment. This meant those assessing the person's continence needs and caring for them did not have all the information available to them.

People living with dementia did not have care plans in place to meet their specific needs. There was no recording of how dementia was affecting them at that time. All plans for people living with dementia stated that the person was able to make their own day to day decisions. With the absence of an MCA assessment and best interests' decision, it was not possible to gauge how staff were ensuring they were meeting people's needs. This meant their care was not personalised. Where people were recorded as having behaviour management challenges for staff, records did not evidence any risk management or mitigation. For example, one person had Parkinson's, Lewy body dementia and vascular dementia, however the care planning did not reflect their mental capacity or plan effectively for their needs when displaying challenge or being resistant to personal care. This meant staff did not have the information available to support this person.

Activities had not been planned around individual needs. Dedicated staff provided activities for people to remain physically and cognitively stimulated. People's care plans did not address how they were to be supported to remain active. We saw activities taking place in the main lounge and this encompassed everyone who was there at the time. The activity was introduced but people were not given the opportunity to take part or not. Staff working as activity co-ordinators had not received dedicated training on how to support activities for people living with dementia.

Not assessing people's care to ensure it is personalised, appropriate and meets their needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they tried to have a routine to meet people's needs such as going to the toilet. Staff were clear that continence pads were used as a back up to supporting people to maintain continence. Also, staff knew who was living with dementia and stated they had training to look after people with a diagnosis of dementia. Staff also described the needs of people living at the service had increased and meeting all their needs was sometimes a struggle. Gaining people's personal history had been picked up as a task to be completed by one of the activity coordinators.

People's spiritual needs were met. People were supported to maintain their faith links and local religious leaders visited the service each month. Some trips out were provided on a small group basis for those of low need. Staff said they wanted to look at how sensory equipment could offer a way forward when meeting some people's activity needs.

People's concerns and complaints were acknowledged and investigated. Most people said they knew how to raise a complaint and felt they could speak to the registered manager. A complaints policy was in place and made available to people and relatives.

Requires Improvement

Is the service well-led?

Our findings

Fairfield House was owned by Fairfield House Healthcare Limited. New directors of the company were appointed in July 2015. A nominated individual was in place to be accountable at the provider level for the service. A registered manager was employed to manage the service locally. They were supported by a senior management team made up of a deputy manager and care lead.

The registered manager had a range of audits in place. The provider had employed the services of a consultant to audit the service. They also had regular contact with the registered manager. However, this had not identified and prevented the concerns being raised in respect of the inspection. For example, systems had not identified the staffing issues, the issues with care plans and personalised care and, we identified people were not having the need for enough to eat and drink met.

Members of the senior management team told us they were exhausted due to the number of hours they were working. This was largely to do with the issues around staffing and the need to ensure people's needs were met. The roles of the registered manager and other members of the senior member team were not defined enough to ensure the service was well-led at the local level. For example, there was duplication of roles and an assumption some tasks were being done such as communication about people's needs and updating care records by other members of the team. Other issues were responded to on an emergency by emergency basis rather than having planned systems in place. The registered manager confirmed that structured times for the senior management team to meet to review the service, or ensure action was taken on audits, was delayed or completed on an ad hoc basis.

Staff felt the communication from the senior management team was good however, the communication could be improved among staff with care responsibilities to ensure they were clear on what the expectations of them were. All staff told us they did not feel staff were working well as a team at the moment and this was affecting people. The registered manager advised meetings with staff had been less frequent due to the staffing issues.

Not having appropriate systems in place to ensure good governance and assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and family members spoke highly of the registered manager and the fact they were approachable. People and family felt comfortable approaching the registered manager. They felt any issues would be heard and acted on. A recent residents' meeting had been held to ask people's ideas on how the service could be run better. People and their families were asked to complete questionnaires to give their feedback on the service. Action was taken in respect of any concerns and feedback given on how concerns had been addressed.

Staff also spoke highly of the registered manager but were concerned as to whether they were receiving enough support to carry out their role fully. One staff member said the registered manager, "Leads well and

we all chip in where needed." All staff spoke to us about the high turnover of staff and the service not retaining staff which was having an effect on all areas of the service. Another staff member said, "Overall it's run pretty well; [the registered manager] will help and do care when we are short", but reflected that the hours the registered manager was working were likely to be preventing other parts of the service being as good.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. A recent notification in respect of a safeguarding issue had not been submitted in a timely fashion. The registered manager said they knew this had taken longer than it should and had put systems in place to address this.

The registered manager had introduced a policy in respect of the Duty of Candour (DoC) and understood their responsibilities. The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong. There was a whistleblowing procedure in place and staff understood their responsibilities to raise concerns about poor conduct. Staff told us they felt confident concerns raised with the registered manager would be addressed appropriately.

The registered manager had systems in place to ensure the building and equipment were safely maintained. Essential checks, such as that of fire safety equipment, took place and action was taken to address any issues raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(a)(b)(3)(b) People's care and treatment was not always appropriate or met their needs. Care and treatment was not always designed with a view to meeting people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1)(2)(3) The registered persons were not acting in accordance with the Mental Capacity Act (2005) to ensure care and treatment of people was provided with consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14(1)(2)(4(a)(b)(d) People's nutritional and hydration needs were not always met to ensure food and hydration was adequate, dietary supplements were not consistently given and people were not always provided with the support required to keep them hydrated.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Regulation 17(1) and (2)(a)

Systems were not always in place to ensure concerns were picked up and met through the quality assurance process.