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

Fairview House provides accommodation and personal care for up to 55 older people, some of whom may be living with dementia. At the time of our inspection there were 49 people residing at the service, two of which were in hospital.

We carried out an unannounced comprehensive inspection of the service on the 17, 18, 20 and 28 July 2017. Previously the service had been inspected in October 2016 and received an overall rating of requires improvement with the domain 'well led' being rated as inadequate. The service was inspected again in March 2017 and was rated requires improvement. At this inspection there had not been sufficient improvements and we continued to have concerns about the safety, health and well-being of people; there had been inadequate management and oversight by the provider to ensure risks and/or potential risks to people were addressed and quality and safety made better.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be 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 so that there is still a rating of inadequate 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 this registration.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. The Care Quality Commission is now considering the appropriate regulatory response to resolve the problems we found during our inspection.

There had not been a registered manager in post at the service since June 2015. It is a requirement of the service's registration with the Care Quality Commission that there is a registered manager in place. 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.

During our inspection we found a lack of governance. There were no robust systems in place to effectively monitor and improve the quality of the service people. Furthermore, the provider had not taken appropriate steps to ensure they had scrutiny and oversight of the service. The lack of managerial oversight had impacted on people, staff and the quality of care provided.

Improvements were required to ensure sufficient staffing levels and deployment of staff to ensure people's individual care and support needs were met. Staff did not always have time to spend with the people they supported to meet their needs; the majority of interactions by staff were routine and task orientated. This was a concern already raised at previous inspections.

Not all risks to people were identified and suitable control measures in place to mitigate associated risks or potential risks. Furthermore, where risks had been identified people's care records had not been reviewed and, where appropriate, updated to mitigate these. Risks to people's health and safety within the general environment were not always safely managed.

Improvements were required to ensure the safe management of medicines. Medicines were administered by senior care workers who had received medication training however no observations of staff's practice had been undertaken to ensure they remained competent to administer medication.

Staff were not provided with the skills, support and knowledge they needed to provide effective good quality care to people. The majority of staff training was out of date. Although staff felt supported by the manager, they had not received formal supervision or appraisal. Staff were not being routinely assessed or checked to ensure they had the right skills and experience to support people using the service.

People's care records were not accurately maintained to ensure staff were provided with clear up to date information regarding people's care and support needs. The process of reviewing people's care plans had fallen behind due to lack of leadership and management and the impact of low staffing levels.

There was a lack of meaningful activities for people to engage in. The environment lacked items of interaction and stimulus to engage people especially those living with dementia. There was a task led and routine led culture at the service and staff did not always have time to spend with people to provide them with person centred care.

Improvements were required to ensure people's capacity to make decisions were being appropriately assessed, recorded and monitored. Although the manager understood the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS), some staff were unable to demonstrate an understanding of the MCA and DoLS and how they would support people so not to place them at risk of being deprived of their liberty.

There was a complaints procedure in place. Although relatives told us that they would speak with the manager if they had any concerns or complaints, some relatives were unsure if they would be listened to. There were no comprehensive systems in place to demonstrate that management learnt from concerns and complaints and that formal analysis of concerns and complaints had been undertaken.

Care records containing people's personal information was not securely stored, maintained and kept up to date.

There were thorough recruitment procedures in place to ensure staff were suitable to work with vulnerable adults.

At our previous inspection, we met with the manager and provider of Fairview House who, at the time, gave clear assurances that improvements would be made to the service and better care and support would be delivered with appropriate staff and governance oversight. This however, has not happened; consequently the Commission is using enforcement pathways to address the shortfalls in quality and the continued breaches of regulations. Some of these actions might not be available as public information at the time of publication of this report as the provider will have a period in which to review our proposals and make representations. The Commission will however, issue a further report as appropriate once this period has passed to tell the public what action has been taken.

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.

Suitable arrangements were not in place to ensure that there were sufficient numbers of staff available at all times to meet people's individual care and support needs.

Improvements were required to ensure risks to people's safety and wellbeing were appropriately managed.

Effective systems were in place to ensure safe staff recruitment.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively to people.

Staff training was out of date.

Improvements were required to ensure people maintained good health, including ensuring monitoring charts such as food and fluid intake and repositioning charts were completed accurately and in a timely manner.

Not all staff were able to demonstrate an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Improvements were required to ensure people's capacity to make decisions were being appropriately assessed, recorded and monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Although some people stated that staff treated them with care and kindness, care provided was often task focused and routine led.

People's dignity was not always respected.

Improvements were required to ensure information detailing people's preferences and choices for their end of life care were clearly recorded, communicated and kept under review.

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 clearly recorded their current care and support needs.

People were not engaged in meaningful activities or supported to pursue pastimes that interested them□.

Although the provider had a complaints policy in place it was unclear how concerns and complaints were being effectively monitored.

Is the service well-led?

Inadequate

The service was not well-led.□

There was no registered manager.

There was a lack of oversight and scrutiny by the provider.

The provider's quality assurance systems and processes did not ensure that they were able to effectively assess, monitor and mitigate the risks relating to people's health, safety and welfare.

The provider was not meeting regulatory requirements.

Care records were not securely stored, maintained, complete and up to date.

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 checked 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 the 17, 18, 20 and 28 July 2017 and was unannounced. We also spoke with relatives by telephone on the 31 July 2017 and 3 August 2017. The inspection was prompted by information of concern shared with the Commission about the quality of care and support provided at the service, staffing levels and the number of safeguarding incidents.

The inspection was completed by two inspectors. On the 17 July 2017 inspectors were accompanied by a member of the Care Quality Commission's medicines team 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. The expert by experience at this inspection had personal experience of caring for older people.

Prior to our inspection we reviewed information we held about the service. This included notifications we had received about the service. Notifications are important information about events which the provider is required to tell us by law. We also looked at records of safeguarding alerts, previous inspection reports and considered information which had been shared with us by the local authority.

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 the inspection we spoke with seven people who used the service, nine relatives, a health and social care professional, seven members of care staff, the home manager, care supervisor, and the commercial director acting as representative for the provider. We reviewed 11 people's care plans and care records. We looked at the service's staff support records for seven members of staff. We also looked at the service's arrangements for the management of medicines, complaints information and quality monitoring and audit

information.

Inadequate

Is the service safe?

Our findings

At an inspection completed in October and November 2016 we identified that staffing levels and the deployment of staff were not always adequate. At our last inspection carried out in March 2017 we found improvements were still required. We met with the provider on the 29 March 2017 who assured us that appropriate staffing levels at Fairview House would be maintained. However despite these assurances we continued to have concerns regarding staffing levels. We discussed these with the manager who informed us that there was a shortage of staff which impacted on the day to day running of the service. They went on to tell us that they were actively recruiting to the vacant care worker posts. At our last inspection in March 2017 the provider assured us that the use of agency staff would be promoted and used to maintain staffing levels when required. We noted that agency staff were not being used and, when we discussed this with the manager, they told us they were not authorised to use agency staff. Relatives told us that they did not feel there were enough staff to keep people safe and ensure their family member's needs were consistently met. One relative told us, "I am beginning to wonder whether [family member] is safe due to staffing levels." Another relative said, "As a home I don't think it is very good. [Family member] has been stabbed twice in the hand by another resident and has fallen out of bed and [staff] were unable to explain how. I don't think there is enough staff for the quantity of people here."

We reviewed rostering records and found that some staff had worked excessive hours. For example one care worker had worked 91.3 hours in one week, taking 3.88 hours breaks. Another care worker had worked 81.42 hours in a week and records showed they had taken 5.35 hours breaks. We discussed this with the manager who informed us it was staff's choice to work these hours; this was confirmed to us by one of the care workers. However, other care workers we spoke with told us they felt they had to work additional shifts in the absence of a full complement of staff as failure to do so would leave the service short of staff on some shifts. No risk assessments of care workers working long hours had been undertaken by management so as to ensure the safety and welfare of people living at Fairview House and staff.

We sought clarification from the manager on how staffing levels were assessed. We were informed that a dependency tool was in place to determine staffing levels but this had not been used since March 2017; the manager told us that the dependency tool was ineffective. They were unable to confirm how staffing levels at the service had been calculated from April 2017 to the 17 July 2017. This meant that staffing levels had not been regularly reviewed to ensure people's fluctuating care and support needs could be met safely and effectively. Throughout our inspection we observed minimal interactions with people where care workers were able to sit down and talk with them as they were often task focussed and routine led.

Following our inspection the provider sent to the Commission an action plan which stated that a new dependency tool to determine staffing levels based on people's fluctuating care and support needs was to be implemented with immediate effect and, pending the recruitment of additional care workers, agency staff would be used to cover staff shortage. However, notwithstanding the provider's planned changes the provider had failed to address our concerns around inadequate staffing levels which had been identified and discussed with the provider following previous inspections undertaken in March 2017 and October 2016. The Commission was not assured that the required measures would be taken to ensure effective staffing

levels and deployment of staff to meet people's social and healthcare needs consistently.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspections in October/November 2016 and March 2017 we identified that improvements were required to ensure appropriate measures were in place to mitigate identified risks to people. At this inspection we found significant improvements were required as we found people were still at risk of not receiving appropriate care and support to keep them safe and maintain their health and well-being.

Not all medicines were stored safely for the protection of people who used the service. On the first day of our inspection we found boxes of medication which had been delivered to the service left open in an unlocked office, we brought this to the immediate attention of the manager. We also found topical creams in people's rooms which had been prescribed to other people being used. When we discussed our findings with the manager they could not provide a rationale as to why these creams were in people's rooms or able to demonstrate that robust checks were in place to mitigate these risks.

In May 2017 the provider introduced an electronic system for recording medicines administration. Controlled drugs were stored safely; however, we saw the balance of three medicines was incorrect. This was because staff were not recording in the controlled drug register when they administered medicines to a person, although the administration had been recorded on the electronic medication record for that person. By reviewing the electronic entries we were able to determine that an actual administration error had not occurred. Medication records also showed that one person had not been administered their prescribed transdermal weekly pain relieving patch for one week. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream over a period of time. This meant that the person went seven days without pain relief. The electronic system produced a daily management report which identified any missing entries and if any medicines were not available. No formal medication audits had been completed by the manager since our last inspection in March 2017. Although medicines were administered by senior care workers who had received relevant training, records showed that no observations of staff's practice had been undertaken to ensure they remained competent to administer medication.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual 'when required' protocols, were in place. This meant there was information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they need them and in way that was both safe and consistent. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature. This meant that although there had been some improvement since our last inspection in some areas in terms of medication management, there were still shortfalls which we were given assurances would be addressed.

Prior to our inspection the Commission had written to the provider following concerns at one of the provider's other services where we had identified they had failed to assess the risks to the health and welfare of people from extreme heat following a period of hot weather. Following our letter the provider confirmed heat risk assessments would be completed for all people living in its services by 10 July 2017. On the first day of our inspection although the manager was aware that these needed to be completed, we found that no heat risk assessments had been completed. This meant that the additional risks to people's health, safety and wellbeing from extreme heat had not been identified, recorded and planned for. Moreover no action had been taken following an amber heat alert by Public Health England published on 16 June 2017 in

relation to excessively hot weather. Whilst we noted no negative impact to people living at Fairview House the omission to complete the heat risk assessments demonstrated the service did not have effective processes in place to protect people who are vulnerable due to frailty and health conditions during spells of high temperatures.

Not all risks to people were identified and suitable control measures in place to mitigate these or potential risks. Furthermore, where risks had been identified people's care records had not been reviewed and, where appropriate, updated, for example, when people had been discharged from hospital or following visits from health and social care professionals. We also saw in the care records for one person whose needs had changed significantly as they were now cared for in bed and were solely reliant on care workers for all their care and support needs that, although staff intuitively knew the person's care and support needs, their care plan and associated risk assessments had not been reviewed to reflect these changes. We discussed this with the manager who could provide no rationale as to why the person's care plan and risk assessments had not been updated since March 2017. On further exploration it transpired that the member of staff responsible for the updating of the person's care and support needs had gone on maternity leave and no one had overseen this task in their absence. We noted four other people's care and support needs and associated risks had not been reviewed following the member of staff going on maternity leave. We also found that for two people who had recently come to live at the service that no care plans and associated risk assessments had been completed despite one person being admitted and discharged from hospital since their first admission to the service. This meant there was no clear guidance/information for staff to follow to ensure their care and support needs were safely and effectively met. The manager could provide no rationale as to why the care plans were not in place, other than staff shortage.

Where people were at risk of developing pressure ulcers, preventative measures were not always being followed or there were no interventions in place on how to mitigate or manage the risk of developing pressure sores. For example where people were cared for in bed and it was recorded that they required two hourly turning; it had been recorded on the majority of the turning charts we viewed that the person had remained on their back. Although the manager informed us that no one living at the service had pressures sores at the time of our inspection, we were not able to determine whether people had been repositioned appropriately thereby placing them at risk of developing pressure areas due to continued pressure on an area of their body for extended periods of time. Training information provided to us showed that all care workers working at Fairview House including the manager did not have up to date pressure ulcer prevention training. Although there was no direct impact on people's health at the time of our inspection, completion of these types of records remains outstanding from our previous inspection and was unacceptable.

Witnessed and unwitnessed falls were recorded on a monthly basis. However, no comprehensive analysis by management had been undertaken to identify trends, determine the cause of falls and take any necessary follow up action. Records also showed that reviews of people's care and support needs and, where appropriate care plans and risk assessments updated, had not always taken place following a fall. One person had had a number of recent falls and undergone hip surgery; their care plan and risk assessment had not been updated following these incidents. For another person we noted their falls risk assessment stated that this area of their care should be reviewed weekly until the risk level had reduced; records showed weekly reviews had not been undertaken. Although we saw that the service had requested a visit from the falls team to carry out a review for this person, the recommendations from the review had not been transferred to the person's care plan.

Risks to people's health and safety within the general environment were not always safely managed. On the first day of our inspection we identified a number of risks such as equipment including wheelchairs and a rusty catheter stand in a communal bathroom. We brought this to the immediate attention of the manager

on the first day of our inspection who informed us they were unaware the equipment was being stored there and would arrange for it to be moved. We noted this equipment was still stored in the communal bathroom on the third day of our inspection. We also saw damaged furniture and cracks in hand basins in some people's bedrooms. In two people's bedrooms we found faeces on the floor and requested for the rooms to be cleaned immediately. We requested to see cleaning schedules but were informed there were none. There were no robust systems or records in place to assure us that regular monitoring of the general environment of the service was being undertaken to ensure infection control measures were appropriate and that people were kept safe from the risk of cross infection.

On the 20 July 2017 the manager was unable to demonstrate that weekly fire alarm testing was being conducted in line with the provider's policy. The manager and care supervisor informed us that the maintenance person at the service had responsibility to undertake the weekly fire alarm tests and did not know where the records for these were kept. At the time of our inspection the maintenance person was on annual leave. We asked what arrangements were in place to undertake the testing in their absence. Both the manager and care supervisor confirmed none of the staff were aware of how to carry out the weekly fire alarm testing and the care supervisor advised they would arrange to get a maintenance person from one of the provider's 'sister' homes to conduct a test. When we revisited the service on 28 July 2017 no fire test had been completed. A health and safety audit had been completed by the provider on 28 June 2017 and the information regarding the date of the last weekly fire alarm test had not been completed. The provider was unable to demonstrate that weekly fire alarm tests had been completed.

There were no effective systems in place to learn from accidents and incidents. Incident and accident records were not analysed to ensure any trends or concerns could be identified. This meant we could not be assured that the manager and provider had an overview of accidents and incidents which occurred at the service and were therefore unable to put measures in place to prevent reoccurrence.

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

The service had safeguarding procedures in place and records showed that safeguarding incidents had been raised although no formal analysis had been undertaken following safeguarding incidents. During our inspection we noted that the manager had failed to recognise a potential safeguarding incident for one person and had not involved relevant healthcare professionals to try and support the person. We discussed our concerns with the manager on the first day of our inspection, 17 July 2017, and advised a safeguarding alert should be made to the Local Authority. This had not been completed by the last day of our inspection, 28 July 2017 and we were assured again that a safeguarding alert would be raised that day; however the incident was not received by the Local Authority Safeguarding team until 7 August 2017.

During another incident a person living with dementia had left the home unsupported by staff. Care records showed that the person was at risk of wandering and absconding. Control measures to mitigate the risk had included for staff to record the person's daily attire, staff to ensure the main entrance door to the building is secure when letting visitors out and to closely monitor the person's whereabouts throughout the day and night. The risk assessment was last reviewed in February 2017 and had not been reviewed following the incident when the person went missing from the service. Care records also showed that the control measures in place had not been adhered to. Although the person was located quickly and had not come to any harm, the manager was unable to demonstrate that a thorough analysis had been undertaken to try and determine what had happened and to ensure robust measures were place to mitigate reoccurrence to protect the person from risk of abuse and harm.

Care workers we spoke with were able to demonstrate an understanding of the different types of abuse and how to respond appropriately where abuse was suspected. However, the staff training information provided to us showed that only two out of 39 staff employed by the service had recent safeguarding training, 10 staff had not received any training and four staff were currently in the process of completing training. 'Ask Sal' posters were displayed throughout the service. 'Ask Sal' is a confidential helpline for people, relatives or staff to call if they had any safeguarding concerns.

During the period 8 June 2016 to 12 July 2017 13 safeguarding alerts were received by the local authority. Eight of the safeguarding alerts were in respect of neglect, one for neglect/physical abuse and two in relation to physical abuse; the types of abuse for two safeguarding alerts have not been determined. One safeguarding alert has been substantiated by the local authority and four have been 'unsubstantiated' and closed. The remaining safeguarding alerts are subject to on-going investigation. The Commission is working closely with the local authority as they investigate these.

During our inspection the manager was unable to demonstrate that all safeguarding incidents were thoroughly analysed and measures put in place to mitigate reoccurrence. This meant that people were not always protected from the risk of harm and abuse.

The above examples are a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014

Effective systems were in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

Inadequate

Is the service effective?

Our findings

At our previous inspections in October 2016 and March 2017 we identified improvements were required to ensure staff received regular supervision, appraisal and training. At our inspection carried out in March 2017 the manager told us they would be ensuring formal supervisions and competency checks of staff practice would be undertaken bi-monthly.

At this inspection we found that significant improvements were still required to ensure staff were provided with the skills, support and knowledge they needed to provide effective good quality care to people. Staff training records showed that the majority of training was out of date. We also saw that, although staff told us they felt supported by the manager, they had not received formal supervision or appraisal in line with the provider's policy. Supervisions and appraisals are important as they are a two-way feedback tool for the manager and staff to discuss work related issues, staff practice and training needs. Some staff we spoke with informed us they had experienced personal issues which had affected their ability to attend work. On reviewing the staff members' folders we saw that this information had not been documented and there was no evidence to demonstrate they had been supported by the manager during this period, despite staff telling us the home manager had supported them.

The manager and care supervisor were unable to provide us with a clear rationale as to why staff's training was out of date or to the lack of staff supervision and observations of staff practice. They informed us a new electronic training programme was currently being implemented which would enable effective monitoring of staff training including alerting management when training is due/overdue. Despite these assurances we could not be assured that the competencies and knowledge of staff were being routinely assessed or checked to ensure they had the right skills and experience to support people using the service or that staff were being appropriately supported to fulfil their role and responsibilities.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The mealtime experience for people was task focussed and was not a relaxed or social occasion. We observed limited interactions with people due to the lack of appropriate staffing numbers and deployment of staff. We observed two people being assisted to eat their meals with limited interaction from staff. This included a new member of staff who had not completed their induction training and had no prior experience of working within a care setting being left unsupervised supporting a person to eat their meal. In one of the lounges we saw seven people who, with the exception of one person, were experiencing difficulty eating their meals. No care staff remained in the lounge whilst they were eating. One person appeared to 'give up'. We observed another person drop their fork and, being unable to get up, began to eat with their knife. We immediately went to find a member of staff. Due to the chaotic nature during the meal time we could not be assured that people's food intake was being accurately recorded or that people were safe due to the lack of staff presence. However one person told us the food was excellent and went on to say, "You don't go hungry here. Always a choice."

There were no systems in place to effectively monitor people's fluid intake, where required. People's fluid

intakes were not being clearly recorded including the totalling of people's daily fluid intakes. Furthermore no individual targets for fluid intakes had been recorded on people' fluid intake charts. This meant that people were at potential risk of dehydration or infection.

Where people had lost weight it was not always clearly recorded in their care plans what actions had been taken, such as a referral to the speech and language team (SALT). We saw that one person had lost 2.7kg between 27 April 2017 and 1 June 2017. Although a referral had been made to the SALT the outcome of the assessment and recommendations from the SALT had not been clearly recorded in the person's care plan.

This was a breach of Regulation 14 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 application 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.

Although the manager had a good understanding of the MCA and DoLS, records showed that care staff had either not completed or had not received refresher Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Not all of the staff we spoke with, including senior staff, were able to demonstrate an understanding of MCA and DoLS and how these should be applied. Furthermore some of the care records we looked at did not have up to date MCA assessments in place and we could not determine how the service was helping people to make decisions. Records also showed that MCAs were not always reviewed when people's care and support needs had changed. At our inspection in October/November 2016 we found not all staff responsible for reviewing and assessing people's ability to make an informed decision were able to demonstrate a good knowledge and understanding of the MCA and DoLS; and did not understand the legal requirements of the MCA despite receiving training. At our last inspection in March 2017 we were assured by the home manager that improvements would be made with regard to this aspect of people's care and that staff would receive appropriate training. Whilst we found no impact to people living at Fairview House due to the lack of up to date MCA assessments and staff training, improvements were required to ensure people's capacity to make decisions were being appropriately assessed, recorded and monitored.

The above failings demonstrated a continued failure by the provider to ensure regulatory requirements were being adhered to. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were supported to access healthcare services and professionals such as GP and hospital appointments and the community nursing team. A visiting health care professional told us, "The staff are knowledgeable and helpful and follow advice. If needed they will make referrals in a timely manner." The outcome of visits/appointments was recorded in people's care plans however this was not always consistent and people's care plans were not always updated. For example the outcome of a visit for one person from health care professionals on 12 July 2017 resulted in the person's medication being changed to

alleviate their agitation. As at the 17 July 2017 the person's care plan and associated risk assessments had not been updated to reflect their current needs.

Requires Improvement

Is the service caring?

Our findings

At our inspection in October/November 2016 we found that, although people and relatives reported kind natures of staff, not all care provided was seen to be person centred and caring. People were not consistently treated with dignity and respect and staff were not always mindful of people's privacy. At our inspection in March 2017 we found improvements had been made and found caring to be good. However, at this inspection we found the improvements from our last inspection had not been maintained.

At our last inspection we identified that people's preferences and choices for their end of life care were not clearly recorded, communicated and kept under review. At this inspection we found no action had been taken by the manager to address this area of care. During our inspection one person had been deemed as requiring end of life care. No end of life care plan was in place for the person detailing their wishes and preferences for their end of life care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that staff were kind and caring. One person told us, "I feel very safe here. The staff are most capable and very friendly." Another said, "I feel sorry for the [carers] they are so busy and rushed off their feet but the care they give is exquisite." However, although we saw some good interactions between staff and people which clearly had a positive impact on people, the majority of interactions we observed throughout our inspection were task led and routine led. Improvements were required to ensure personalised care was provided to people. From our observations and the feedback we received from people, relatives and staff, it was evident that current staffing levels and the ineffective deployment of staff contributed to the lack of good quality care.

There was little or no evidence to indicate that people using the service or those acting on their behalf had been involved in the care planning process and review of their care. Some of the relatives we spoke with told us that they had contributed to the pre assessments prior to their family member moving into Fairview House however they had not been involved in the on-going review of their family member's care.

People were not always treated with dignity and respect. Whilst we observed staff knocking on people's doors before entering and calling people by their preferred terms of address, we found an uncovered commode in one person's bedroom had not emptied for 1.5 hours despite a member of staff recording in the person's care records that they had been present when they had emptied their bowels.

People's personal records were stored in an unlocked cupboard in an unlocked office when not in use. This meant that people's information was not protected so as to ensure confidentiality.

People were supported to maintain contact with family and friends. Relatives told us that they were always welcomed and that there were no restrictions on visiting times. One person told us that their children and grandchildren could visit at any time which enabled them to fit their visits around their life and work

commitments.

Inadequate

Is the service responsive?

Our findings

At our previous inspections in October/November 2016 and March 2017 we found that people's care plans were not sufficiently detailed or accurate to include all of a person's care needs or the care and support to be delivered by staff. At this inspection we found people's care plans were out of date and therefore we were unable to ascertain whether people's preferences, wishes and aspirations were being promoted. Furthermore there was a lack of clear guidance and key information in people's care plans to enable staff to support people with their specific health conditions such as epilepsy or catheter care. This included the signs and symptoms to be aware of, or their relevance to indicate a risk to a person's health, safety and wellbeing. This meant staff may not recognise the need to take action in order to prevent people from becoming seriously unwell. Care plans did not always provide sufficient guidance and actions for staff to take if people became agitated or anxious. One person's care plan stated they can become agitated but the care plan did not contain detailed information on the triggers that might make this worse, or ideas about how to distract or engage positively with the person. Without this understanding, staff were unable to provide person centred care which ensured their well-being. The manager was aware that people's care plans were out of date and told us their focus was on ensuring people were well cared for and that the shortage of staff had negatively impacted on their and senior carers' ability to review and update people's care plans. At our last inspection we were informed that plans were underway to implement computerised care plans which would address the issues we had identified, this had not yet been implemented. We were advised by management and the provider that the new electronic system would be introduced imminently.

People's social and wellbeing needs were not being met. The provider states on their website, 'We know that providing excellent care can make a huge difference to people with dementia. We provide a comfortable and secure environment that is stimulating and preserves and enhances residents' life skills. We do this through reminiscence. By triggering and exploring memories of the past we build self-confidence and most importantly we aim to keep residents engaged and communicating.' We found this was not an accurate reflection of the service. We found that people had limited opportunity to engage in activities and pastimes that interested them. Significant Improvements were required to ensure staff supported people to lead meaningful lives and to participate in social activities of their choice and according to their abilities including people living with dementia. It was clear from our observations during our inspection, speaking with relatives and from information recorded within people's care plans, that people's social care needs were not being met.

At our last inspection the service did not have an activities coordinator. At this inspection the recruitment process had not been completed. No interim arrangements had been made in the intervening period nor had any action been taken following feedback from our specialist advisor for dementia that a good weekly activity programme was missing with stimulating, engaging programmes scheduled for different days of the week. Although televisions and music were on in some of the communal areas, people were not seen to take an interest. In one of the communal lounges we saw that on one day during our inspection the television was not receiving an aerial signal and a distorted screen was showing, the television was subsequently turned off. One relative told us how their family member sat in a chair all day long and there was a lack of activities. They went on to say, "I have said about this to the carers and their response is 'we can only do

what we can do'. I feel sorry for the carers, there's just not enough [carers]." Another relative told us how their family member required staff to hoist them out of bed. They went on to say that their relative would often have to wait to be hoisted by staff and that some days they did not get out of bed at all. The relative was concerned their family member's health and well-being was deteriorating and they were at risk of becoming isolated. Our observations throughout our inspection were that the majority of people remained sitting in the same chair all day, many asleep or disengaged with their surroundings due to the lack of occupation or stimulation.

The service was not responsive to people's care and support needs. People did not receive person centred care. Moreover, the provider had failed to address the issues we had identified at our previous inspections.

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

There was a complaints procedure in place. Although relatives told us that they would speak with the manager if they had any concerns or complaints, some relatives told us were unsure if they would be listened to. At our last inspection the manager had created a complaints log to aid analysis and to drive improvements. However records showed that there were no comprehensive systems in place to demonstrate that management learnt from concerns and complaints and that formal analysis of concerns and complaints had been undertaken. We looked at a recent complaint received by the service in June 2017. We saw that records pertaining to the complaint were incomplete as documentation was missing and it was unclear what actions had been taken. The manager was unable to provide us with an update on the progress or outcome of the complaint as they had not been involved in the investigation of the complaint.

Inadequate

Is the service well-led?

Our findings

At our inspection carried out in October/November 2016 we found a lack of leadership and managerial oversight of the service. The provider responded to our immediate concerns and we met with the provider on 9 November 2016 to gain assurances from them that the findings from our inspection were being addressed. At our inspection in March 2017 the provider had recruited a home manager who had been in post since January 2017. We found good management and leadership were present within the service. The home manager had identified areas for improvement and explained to us the actions they would be taking to address shortfalls within the service. There has been no registered manager at the service since June 2015.
The Commission met with the provider on 29 March 2017. At this meeting we raised concerns about the retention of management at Fairview House and the need to support and utilise the skills of the current home manager and work collaboratively with them to enable the provider to have an increased oversight of the service so as to ensure high quality care was consistently delivered. At this inspection both the provider, care supervisor and home manager were unable to demonstrate that effective systems had been implemented and embedded. We continued to have concerns about the day to day management and oversight of the service.

There were no robust quality assurance systems in place to effectively monitor the service to ensure people's safety and mitigate risks relating to their health, safety and welfare. We asked to look at the auditing which had been undertaken since our last inspection. With the exception of one health and safety audit which had been completed in June 2017, management could not evidence what quality assurance they had undertaken or the actions they had carried out since our last inspection in March 2017. This included the review of people's care plans to ensure they reflected people's current care and support needs, robust analysis of incidents and accidents including witnessed and unwitnessed falls, safeguarding incidents, staffing levels, safe management of medicines, providing person centred care and the home manager conducting regular walks around the service to identify risks within the home's environment. Improvements were also needed to record keeping as there were inconsistencies in the accuracy of information contained in people's care records, examples of these have been highlighted in the safe, effective and responsive sections of this report. Inaccurate or incomplete information in care records places people at risk of not receiving the care they need. This further demonstrated to us that there were ineffective systems in place to accurately assess and monitor the service. Moreover there was a lack of scrutiny and oversight on the provider's behalf regarding how the service was identifying areas for improvement and taking the appropriate actions. Significant improvements were required to ensure effective quality assurance systems were in place to drive improvements.

No resident/relatives meetings had taken place since our last inspection although we noted one was scheduled for 31 July 2017. However some of the relatives we spoke with following our inspection were not aware of the relatives meeting. People and those acting on their behalf had not been involved in the review of their care. This showed us that there were limited opportunities to seek the views of people using the service or to enable and empower them to be involved in making decisions about the day to day running of the service and to continually improve the service.

The manager and care supervisor could not evidence how they were moving the service forward. It was apparent from our inspection that the absence of robust quality monitoring and lack of auditing processes was a contributory factor to the failure of the manager and the provider to recognise breaches or any risk of breaches with regulatory requirements.

The manager had not received formal supervision since our last inspection and it was unclear how they were being effectively supported by the provider to meet regulatory requirements. Our observations showed that the support and resources required to run the service were not available and the provider was not operating the service in line with their own philosophy of care which stated that, 'Our belief in caring for the elderly is to maintain the highest standards of quality care. Our abiding personal and professional concern is safeguarding the interest and well-being of all residents as well as offering person-centred care.'

The above failings demonstrated a continued failure by the provider to ensure regulatory requirements were being adhered to. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the manager and they were approachable and operated an 'open door' policy. Staff meetings had been held in July 2017 and minutes from these meetings showed staff morale was low due to the impact of insufficient staffing levels.

During our inspection the provider informed us that following our feedback they were in the process of reviewing all the systems and processes in place to ensure their audit and governance systems were safe and effective. However, due to the seriousness of our concerns we wrote to the provider on the 25 July 2017 requesting an urgent action plan from them to tell us what they were going to do to make improvements and ensure regulatory requirements were met. This was followed up with a meeting with them. We will continue to monitor the service and the provider's action plan.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service users' social and well being needs were not being met. Service users had limited opportunity too engage in activities and pastimes that interested them. Care plans were out of date. Some care plans lacked clear guidance and key information to enable staff to support them safely and effectively.

The enforcement action we took:

Notice of Proposal to impose condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not seeking or recording consent to care in line with legislation and guidance.

The enforcement action we took:

Notice of Proposal to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Improvements were required to ensure medicines were stored safely and service users received their medication as prescribed. Risks to service users were not always assessed. Care plans and associated risks were out of date and had not been reviewed following significant changes in service users' care and support needs. There were no effective systems in place to analysis incidents and accidents.

The enforcement action we took:

Notice of Proposal to impose condition of registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment No formal analysis had been undertaken following safeguarding alerts. The systems and processes to effectively investigate, immediately upon becoming aware of, any allegation or evidence of such abuse and to mitigate reoccurrence were not robust.

The enforcement action we took:

Notice of Proposal to impose condition of registation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The systems and processes in place to effectively ensure that service users received adequate nutrition and hydration were ineffective.

The enforcement action we took:

Notice of Proposal to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place to effectively assess, monitor and improve the quality and safety of the service, including the risks to the health, safety and welfare of service users and others who may be at risk were ineffective.

The enforcement action we took:

Notice of Proposal to impose condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at the service to ensure the care and support needs of service users could be safely met. Staff training was out of date and staff had received no supervision or appraisal to support and enable staff to carry out their duties and fulfil their role.

The enforcement action we took:

Notice of Proposal to impose condition of registration