

Far Fillimore Care Homes Ltd

Far Fillimore Rest Home

Inspection report

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Date of inspection visit:
08 November 2023

Date of publication:
21 December 2023

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Far Fillimore is a residential care home providing accommodation and personal care to up to 26 older people, some of whom were living with dementia. At the time of our inspection there were 20 people using the service.

People's experience of the service and what we found:

People were not always safeguarded from the risk of abuse and action was not always taken to mitigate the risk of harm to people following incidents and accidents. Systems in place did not support continuous learning. People's risk assessments were not always followed, and this put them at risk.

The environment was not always safe for people. Window restrictors did not meet health and safety guidance and safety checks were not always undertaken on a regular basis. Although the home was clean, there was a malodour in the ground floor bedroom corridor.

Quality monitoring systems had not ensured that the service was safe. The registered manager undertook monthly audits, however these were not effective in analysing trends and identifying improvements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

The last rating for this service was Good and the report published on 23 April 2018.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

You can see what action we have asked the provider to take at the end of this full report. We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Far Fillimore on our website at www.cqc.org.uk.

Follow Up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Requires Improvement ●

Far Fillimore Rest Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection team consisted of an operations manager, an inspector 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.

Service and service type

Far Fillimore is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Far Fillimore is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection

The inspection was unannounced

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and

improvements they plan to make.

During the inspection

We spoke with 6 people who used the service and 1 relative about their experience of the care provided. We had correspondence with 1 professional who had contact with the service. We spoke with 4 members of staff including the registered manager.

We reviewed a range of records. This included 4 people's care plans, a range of medicine administration records (MAR) and 4 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems. We spent time observing the care that people received within the home.

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse and avoidable harm

- People were not always safeguarded from abuse and avoidable harm.
- We saw records that showed that 2 people had experienced unexplained bruising to their body. Staff had completed body maps recording this, however, no action was taken to investigate how the bruising had occurred.
- One of these people told staff that other staff members had caused the bruising. The registered manager had not reported this incident or the other person's bruising to the local authority for investigation.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management Learning lessons when things go wrong

- The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks.
- Staff did not always follow people's individual risk assessments. We saw a record of an incident where 2 people who were assessed as requiring a member of staff with them when walking had been walking with other people without staff. There had been an incident which would not have occurred if staff had been present as is required. This put these people at risk of harm.
- The provider did not always learn lessons when things had gone wrong.
- We looked at incidents and accidents and saw that some people experienced frequent falls. On some of the records it was noted that the person's sensor mat had not gone off when they were found. No action was seen to be taken to ensure that the sensor mat was in working order and no action was recorded to prevent or reduce the risk of the person falling again.
- We noted that the window restrictors, on the top floor of the home were not meeting health and safety guidance. This put people at risk of falls from height. The registered manager took action the following day to have new window restrictors fitted.

These issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The registered manager told us they felt there were sufficient numbers of suitable staff. However, we could not see that the agreed staffing levels were based on people's assessed needs.

- A member of staff told us, "Some residents walk around and fall and we can't watch them 24 hours a day".
- We saw a recorded incident where staff should have been supporting 2 people when walking, when an incident had occurred. The incident could have resulted in harm.
- Accident reports recorded regular falls throughout the home. We noted that although there were sensor mats in place for people at risk of falling, staff often got to people too late and had found them already fallen. The layout of the home meant staff often had some distance to travel when the sensor alarm went off.
- A member of staff told us, "A lot of the residents need a lot of support. Some have dementia, a lot need assistance. The problem is they have some residents wandering, they don't have the staff to monitor them".
- The lack of staff deployed throughout the home was putting people at risk of harm.

These issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, people we spoke with told us they felt their needs were met in a timely manner. One person said, "If I ring my bell, they come quite quick day and night". Another person told us, "If I ring the bell, someone always comes very quickly."
- The provider operated safe recruitment processes.

Using medicines safely

- People were supported to receive their medicines safely.
- Medicines were stored and administered safely. We checked stock levels and these corresponded with what was recorded on the medication administration records (MAR).
- People told us they received their medication as prescribed and when they required it. One person told us, "I wear patches now for the pain in my knees and staff change these for me and if I want painkillers, they will give them to me." Another person told us, "The staff bring me my tablets regularly and pain killers when I want them".

Preventing and controlling infection

- People were protected from the risk of infection as staff were following safe infection prevention and control practices.
- The home was visibly clean, and we saw cleaning schedules in place. Staff followed infection control procedures with the use of PPE. However, we noted a strong malodor in the ground floor bedroom area. The registered manager told us this was coming from 1 person's bedroom.

We recommend that the provider takes action to neutralise the smell in the ground floor area to promote a fresher, more inviting bedroom and ground floor area.

Visiting in Care Homes

- People were able to receive visitors without restrictions in line with best practice guidance.

Is consent to care and treatment always sought in line with legislation and guidance?

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements and continuous learning and improving care

- The provider did not have a fully supported management structure. The registered manager told us they managed the home alone with little input from the provider. There was no external scrutiny of the registered manager's roles and responsibilities.
- The provider's systems did not always effectively monitor the quality of care provided to drive improvements.
- The provider had not consistently created a learning culture at the service which meant people's care did not always improve.
- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service. As a result of this, action had not been taken to make the required improvements.
- Falls monitoring did not evidence that trends and themes to people's falls had been identified and any necessary action taken to minimise the risk of falling again.
- Staffing levels had not been assessed based on people's needs. Accident and incident recording had not prompted the provider to consider the staffing levels.
- We saw that records showed that at times the equipment in place to keep people safe was not working. However, no action was taken to check the equipment to ensure it was in working order. This was placing people at risk of harm.
- The registered manager had not recognised that safeguarding referrals were required when there had been accusations of harm and unexplained bruising had been found.
- The provider had not followed national guidance in relation to the fitting of window restrictors within the home. This meant that people were being put at risk.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a positive and open culture at the service.
- The provider had systems to provide person-centred care that achieved good outcomes for people.
- The registered manager and staff knew people well and knew their likes and dislikes.

- People told us they received the care they required in a way that met their individual needs. They told us they were able to get up and go to bed when they liked. One person told us, "I get up about 8.15 get washed and dressed. I like my breakfast in my room, about 8.50 and staff give me my medications. I sometimes stay up till midnight watching tv, then bed."
- Another person told us, "I like to go downstairs in the lift for lunch. I like to go to bed about 9pm and 1 of the carers helps me and I sleep well after they put the light off."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood their responsibilities under the duty of candour. However, they had not always raised safeguarding concerns with the local authority to allow investigation into potential incidents of abuse.
- A relative told us, "They always let me know if my [relative] has a fall or even a slip of the chair".

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

- People and staff were involved in the running of the service and fully understood and took into account people's protected characteristics.
- People knew who the registered manager was and told us that if they had any concerns they would speak to them.

Working in partnership with others

- The provider mostly worked in partnership with others. However, they had not always informed the local authority of incidents which may constitute abuse.
- Staff worked with other health and social care professionals, such as district nurses and people's GPs, so people would receive the care they needed.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks of harm to people were not always mitigated. People's risk assessments were not always followed to keep people safe.
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from the risk of abuse. Referrals to the local safeguarding authority were not always made when people received unexplained bruising.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems in place were not always effective in ensuring continuous learning and improvement.