Mills Family Limited

Fairlight & Fallowfield

Inspection report

Ashfield Lane
Chislehurst
Kent
BR7 6LQ

Tel: 02084672781
Website: www.millscaregroup.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Fairlight & Fallowfield on 07, 08 and 09 February 2017 which resulted in our taking enforcement action. We served warning notices on the provider and registered manager in respect of a breach found of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We took this action because people using the services risk assessments were not always up to date and action had not always been taken where risks had been identified to ensure their safety was maintained. We also found risks associated with the environment were not safely managed.

We conducted this unannounced focused inspection of the service on 12 June 2017. At the inspection we looked at aspects of the key question 'Is the service safe?' This report only covers our findings in relation to the focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Fairlight & Fallowfield' on our website at www.cqc.org.uk.

Fairlight and Fallowfield is a home providing nursing care and residential support for up to 55 people in the London Borough of Bromley. At the time of our inspection there were 42 people living at the home.

The service had a new registered manager in post who had registered in the time since our last inspection. 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.

At this inspection we found a continuing breach of regulations because whilst the provider had taken action to address all of the issues identified in the warning notices, we could not be assured that pressure relieving equipment in place for one person was safe for use. Following the inspection we wrote to the provider with regards to this issue and they confirmed the action they had subsequently taken to ensure the equipment was safe for use.

We also identified a further breach of regulations because effective systems were not in place to monitor and mitigate the risks associated with the use of pressure relieving equipment and because records relating to people's care and treatment were not always complete and accurate.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Further action was required to improve safety.

Whilst the provider had acted to address environmental risks and ensure people's risk assessments were reviewed, appropriate action had not always been taken where issues were identified to ensure pressure relieving equipment was safe for use.

Systems were not always in place to monitor and mitigate risks to people or to ensure records relating to the management of identified risks were complete and accurate.

Fairlight & Fallowfield

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. We undertook an unannounced focused inspection of Fairlight and Fallowfield on 12 June 2017. This inspection was done to check that improvements had been made to meet legal requirements in response to the enforcement action we took following our inspection on 07, 08 and 09 February 2017. The inspector inspected the service against aspects of one the five questions we ask about services: 'Is the service safe?' This is because the service was not meeting legal requirements in response to part of that key question at the last inspection.

The inspection was undertaken by a single inspector. Prior to the inspection we reviewed the information we held about the home. This included notification submitted by the provider. A notification is information about important events that the provider is required to send us by law. We used this information and the information from our last comprehensive inspection to inform our inspection planning.

During this inspection we spoke with two people, the registered manager and six staff. We reviewed the environment and looked at records, including five people's care plans and risk assessments, and records related to the management of the service, including observation charts relating to the support people received.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 07, 08 and 09 February 2017 we found a breach of regulations because risks to people were not always safely managed and people's risk assessments were not always up to date. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet this regulation.

At this inspection on 12 June 2017 we found that the provider had acted to address all of the areas of concern identified in the warning notice. For example, trip hazards had been removed or boxed off where they could not be removed to reduce the risk of falls around the service. In another example we found infection control concerns identified at the last inspection had been addressed and that cleaning products were stored securely in line with the requirements of the Control of Substances Hazardous to Health Regulations 2002 (COSHH). However, despite these improvements, we also found there was a risk that a pressure relieving mattress used by one person was not safe for use and appropriate action had not been taken by staff to address this issue.

Records showed the person had been assessed as being at very high risk of developing pressure sores and that they had developed a pressure sore during the month prior to our inspection which had been reviewed by a health care professional with specialist knowledge in pressure area care. A subsequent report from the healthcare professional identified a potential problem with a specific function of the pressure relieving mattress which they had requested be referred to maintenance for review. We spoke a member of the provider's maintenance staff to confirm the action they had taken to address the issue but found they had not looked at the specific issue that had been identified and had not contacted the external contractor responsible for maintaining the mattress to request a maintenance visit. This meant there was a risk that the mattress was not safe for use in managing the person's skin integrity.

This issue was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). Following our inspection the provider wrote to us and confirmed they had arranged to the mattress to be serviced by the external contractor.

We also found that there were no effective systems in place to monitor and mitigate the risks associated with the use of pressure relieving equipment. For example, staff were not always aware of how to set the pressure of pressure relieving mattresses to safely support people in bed and there was no system in place to monitor pressure relieving mattress to ensure they were set at correct settings, where this was applicable. In addition, the systems used to ensure pressure relieving equipment was serviced on a regular basis was not effective as staff could not always identify the last service dates of equipment or when a service was next due. These issues meant appropriate systems were not in place to monitor and mitigate risks to people's skin integrity.

Additionally we found records relating to the support people received to reposition where their skin integrity was at risk were not always accurate or had not been completed fully. For example, we reviewed the

repositioning records for two people from the week prior to our inspection and found gaps in recording, or records which showed the person simply as being in bed rather than identifying the position they were lying in. Staff we spoke with told us people had been repositioned during these times but we could not be assured that repositioning had occurred with appropriate frequency to safely meet people's needs as accurate records had not been maintained.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). During the inspection the registered manager and senior staff confirmed they would review the format of repositioning records and follow up with staff to ensure repositioning was recorded accurately and consistently. Following the inspection, the provider confirmed that they had put systems in place to monitor and mitigate the risks associated with the use of pressure relieving equipment.

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 There was a risk that equipment used by the provider was not always safely maintained to meet the needs of service users.

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 17 HSCA RA Regulations 2014 Good governance Systems were not always in place to monitor and mitigate risks to people. Records relating to the care and treatment people received were not always accurate or complete.

The enforcement action we took:

We served a warning notice on the provider and registered manager.