Grimsby Dementia Care Ltd

Fairways Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Fairways Care Home is situated to the west of the town of Grimsby, on a main road with public transport facilities and local shops and other amenities within walking distance. The service is registered to provide accommodation and personal care for a maximum of 55 people some of whom may be living with dementia. Accommodation is single storey and all bedrooms have en- suite facilities. There is a good range of communal areas throughout the building. There is an accessible garden and car parking at the rear of the building. At the time of this inspection 39 people used the service.

The service did not have a registered manager at the time of the 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. The acting manager confirmed they had completed their interview with CQC two weeks previously, to support their application for registration and the certificate was issued on 13 March 2017, five days after the inspection.

We undertook this unannounced inspection on the 6 and 8 March 2017. The last inspection took place on 26 and 28 January 2016. At that inspection we found the service was in breach of one regulation around person centred care and was rated 'Requires Improvement' in all domains and overall. At this inspection we found improvements in relation to the previous breach and the rating in three domains had improved to 'Good'. We found two new breaches of regulations in relation to medicines and notifications. The service rating overall remains 'Requires Improvement.'

We found there were shortfalls in the administration and recording of some people's medicines. This was a breach in regulations and you can see what action we have asked the registered provider to take at the back of the full version of the report.

The Care Quality Commission had not received all notifications for incidents which affected the safety and wellbeing of people who used the service, as required by registration regulations. This had been an error by the registered provider and acting manager and they told us they would forward all required notifications in future. We have written to the registered provider to remind them of their responsibilities in this area.

Improvements had been made with the standard of recording in the care files. A new recording format supported staff to provide more detailed and person centred information. Care plans had been reviewed and updated to reflect the person's current care needs. We found risk assessments were completed, reviewed and updated when people's needs changed. Supplementary records to monitor areas such as food and fluid intake, repositioning support and personal care were well completed and up to date.

We found some improvements had been made with the management of the service. Although aspects of the quality monitoring programme had been reviewed and strengthened, the registered provider considered the

existing system remained limited and had provided a new monitoring programme, which was to be implemented by May 2017.

We found people who used the service were protected from the risk of harm and abuse. People told us they felt safe living in the service. We saw staff interacting with people and they did so in a kind, caring and sensitive manner. Staff had received safeguarding training and knew what to do if they witnessed abuse or if it was disclosed to them. Two staff were not clear about the reporting procedures to external agencies and the acting manager confirmed they would address this through training and supervision. Staff knew what to do in cases of emergencies and each person who used the service had a personal evacuation plan.

We saw there were enough skilled and experienced staff on duty to meet people's needs. A new dependency tool assisted the acting manager to calculate the numbers of staff required. We found staff had been recruited using a robust system that made sure they were suitable to work with vulnerable people.

Staff told us they felt supported by the registered manager and confirmed they had received a range of training, formal supervisions and appraisals of their work. Gaps in the supervision programme were being addressed.

People enjoyed the meals provided to them. The menus enabled people to have choice and special diets when required. We saw people's weight, their nutritional intake and their ability to eat and drink safely was monitored and referrals to dieticians and speech and language therapists took place when required for treatment and advice. During the day, we observed people were served drinks and snacks between meals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff demonstrated good communication skills and distraction techniques when managing people who needed additional support to manage their behaviours.

People were cared for by a stable staff team who knew them well. We saw staff encouraged people to be as independent as they were able to be and spoke with them in a friendly and respectful way. Relatives told us the atmosphere at the service was calm, friendly and open and that staff were kind. The feedback provided by relatives and staff about the acting manager was also positive.

We saw arrangements were in place that made sure people's health needs were met. The service worked closely with community healthcare teams who gave us positive feedback.

A varied programme of entertainment and activities was available; we saw people enjoyed taking part in a music session with entertainers and playing games with staff and volunteers.

There were systems in place to manage complaints and people who used the service and their relatives told us they felt able to raise concerns and complaints.

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.

Some people did not receive their medicines as prescribed.

Staff were recruited safely and were employed in sufficient numbers in order to meet the needs of people who used the service.

Staff had received training in how to safeguard people from abuse and understood the action to take if there were concerns. Two staff were not fully aware of the process of referring concerns to external agencies, which the registered manager was to address. The management of risk had improved.

The service was clean and equipment used was serviced regularly to make sure it was safe.

Is the service effective?

Good

The service was effective.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met. Where people living with dementia were unable to make decisions about their care, we found capacity assessments and best interest meetings had been completed.

Staff training, supervision and support equipped staff with the knowledge and skills to support people safely. Gaps in the supervision programme were being addressed.

People's health care and nutritional needs were met. They had access to a range of health professionals in the community. Menus provided a variety of meals with choice and alternatives. People liked the meals they were provided with.

Is the service caring?

Good

The service was caring.

There had been improvements in the way staff promoted and

supported people's dignity. We observed staff were attentive to people's needs and were caring in their approach.

People were treated with dignity and respect and provided with information about their care and treatment.

Staff had a positive, enabling approach to the care they provided and supported people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Improvements had been made in the way people's needs were assessed and care was planned. This meant the care was more person-centred.

People felt able to complain in the knowledge any concerns would be addressed.

People had good opportunities to participate in a range of meaningful activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Due to a reporting error and delays, the Care Quality Commission had not always received all timely information about issues which affected the wellbeing of people who used the service.

Although some of the audit tools had been reviewed and developed there was an inconsistent and limited approach with some aspects of the quality monitoring programme. A new, up-to-date programme was scheduled for implementation.

The registered manager was visible and approachable. They promoted a fair and open culture where staff felt they were supported.

People and their relatives were able to voice their opinions and views about the services they received.

Fairways 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 registered 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 6 and 8 March 2017 and was unannounced. The inspection was led by an adult social care inspector who was accompanied on the first day by a pharmacist inspector and an expert by experience who had experience of supporting older people living with dementia.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We also looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed. We spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.

We spoke with ten people who used the service and eight of their relatives who were visiting during the inspection. We looked around all areas of the service and spent time observing care. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, administrator, two team leaders, three care workers, a housekeeper, laundry person, the cook and the activity co-ordinator. We spoke with two visiting health and social care professionals.

We looked at the care records of six people who used the service including assessments, risk assessments, care plans and daily recording of care. We looked at other records relating to people who used the service; these included accidents and incidents and medication records for 10 people.

We also looked at a selection of records used in the management of the service. These included staff rotas, training and supervision records, quality assurance audit checks, surveys and minutes of meetings with staff and people who used the service. We had a tour of the premises.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe living at Fairways Care Home and that it was clean and tidy. Most people said staff responded in a timely way when they pressed the call bell. Comments included, "I think it is alright, quiet and clean", "Beautiful, clean and plenty to do", "Very good, the call bell is answered quickly", "Plenty of staff", "Could do with more [staff], but no long waits", "Always someone about if you want them", "Yes, so many people about, and they pop in and out and check I am okay" and "I can lock my room door, I feel safe."

The majority of relatives we spoke with considered the staffing arrangements were satisfactory. Comments included, "Staff are very attentive and always available", "Staff are visible and monitor residents closely", "Staffing levels seem about right", "We could always do with more staff at times" and "Sometimes not, at one teatime visit I was the only one in the room."

Prior to the inspection we had received information of concern about some medicines administration and recording practices. This included a medicines error, when one person had not received their medicine for dementia over a period of time. We checked the medicines systems and found some similar concerns.

All the medication administration records (MARs) we checked clearly stated if the person had any allergies. However, one person had 'no known allergies' recorded on their MAR whilst a handwritten note 'advised by family allergic to penicillin' was recorded in the care plan on 27 December 2016. This meant there was a risk of the person receiving medicines which could serious harm.

We checked the quantities and stocks of medicines supplied outside of the monitored dosage system (this provides medicines in a separate compartment for each dosage time of the day) for ten people and found the stock balances to be incorrect for six of them. This meant we could not be sure people had received their medicines as prescribed. Not keeping accurate balances of medicines increased the risk of not having enough medicines in stock to meet people's needs. For example, one person had not been given a medicine on three consecutive days in March 2017 because there was no stock available. Staff had documented that the medicine was absent on the MAR but had failed to ensure that a further supply was obtained from the pharmacy.

We found gaps in four of the ten administration records we reviewed where staff had not signed or recorded the reason for not administering medicines. In one case, medicines used for dementia had been signed as though they had been given, but we found the tablets were still in the monitored dosage system. This meant records did not accurately reflect the treatment people had received.

Other medicines records were not always clearly completed to show the treatment people had received. One person was prescribed regular pain relief medicine with a variable dose, if required. Staff had signed the MAR on 16 occasions during March 2017 to say the medicine had been given and at what time. However, the time was illegible in some records increasing the risk of medicines being given too close together. Medicines were not being given in a way which met with the individual needs of the person and there was a risk of the

person suffering from pain.

There were gaps in the monitoring of the room temperature where medicines were stored. Checks on medicines which required cold storage showed temperatures had been recorded outside of the recommended range on five occasions in February 2017 and six occasions in March 2017. No action had been taken by the staff and the registered manager had not been informed. This meant we could not be sure medicines stored in the fridge were safe to use.

We found staff had not carried out regular balance checks of controlled drugs in accordance with the home's policy. There was lack of oversight with respect to medicines management and inadequate systems of audit to drive forward improvements. The last medicines internal audit was completed in August 2016 and we saw no actions resulting from identified concerns.

These issues meant there was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the end of this report.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. Staff we spoke with demonstrated a good knowledge of safeguarding people and could identify the types and signs of abuse. They told us they had received initial training in this subject during their induction period, followed by periodic refresher training. Two staff were not clear on reporting procedures to external agencies and that the local safeguarding team was the primary agency to contact. We mentioned this to the acting manager to address and they confirmed they would review the staff training programme and go through external reporting procedures in staff supervision and staff meetings.

Sufficient numbers of staff were deployed to ensure safe and timely care. Staffing numbers were now planned using a dependency calculation which assessed the number and needs of people who used the service. The acting manager showed us the rotas which were consistent with the staff on duty and told us the staffing levels were flexible to support people who used the service.

Staff said they had enough time to undertake care and support and spend time with people. We observed care and support and saw staff were visible and attentive throughout the day. Staff were available to quickly intervene if people became distressed, ensure people received assistance with their meals and to supervise communal areas appropriately.

We found new staff were recruited safely. Staff recruitment files included copies of their application form so gaps in their employment history could be explored; two references, a disclosure and barring service check and interview notes. The recruitment checks in place helped to ensure people were suitable to work in care settings.

We found improvements with the quality of the risk assessment records. People's care and support was planned and delivered in a way that better promoted their safety and welfare. The risk assessments checked were accurate and reviewed regularly, they provided guidance for staff in how to keep people safe and minimise the risks associated with specific activities of daily living. These included areas such as, moving and handling, falls, pressure damage, nutrition and the use of equipment such as bedrails. For example, records showed how one person had been found to be at potential risk of harm from falls. The assessment had looked at factors such as current medication and assessed their mobility in order to put a risk reduction plan in place. We noted that risks associated specifically with swallowing and choking were not assessed separately from general nutritional risks which the acting manager confirmed they would address. Staff we

spoke with understood the risks presented by people we asked them about.

We saw accidents and incidents were investigated and appropriate action was taken to prevent their re-occurrence. For example, outcomes showed the involvement of healthcare professionals and the introduction of technology such as sensor mats to assist staff in monitoring people's safety. Incidents were better analysed and reviewed closely as part of the audit process. We received positive feedback from the falls physiotherapist who considered the staff took appropriate action to minimise risks to people.

The service was clean and tidy. We noted the carpet in one person's bedroom had a strong mal- odour and the acting manager confirmed the carpet was scheduled for replacement at the end of the week. Equipment used in the home was serviced at intervals to make sure it was safe to use. We found risks in relation to the building were managed, with contingency plans in place for emergencies. We saw people had personal emergency evacuation plans, which provided staff with guidance in how to support people to safety quickly and efficiently when required.

Good

Is the service effective?

Our findings

People who used the service told us staff supported them effectively. People were also complimentary about the meals provided; they told us they received sufficient amounts to eat and drink and there were always choices of meals available. Comments included, "They arrange the doctor if I need one and the nurse comes in regularly" , "Excellent food, good choices", "Puddings are smashing" and "I had poached eggs for breakfast, we get a couple of choices."

Relatives told us, "Meals seem to be very good. Other options are available if the menu is not liked. Frequent drinks and snacks given", "Staff do their best to encourage [name of family member] to eat and drink, always offering their favourite snacks" and "Staff are well trained in moving and handling, we have observed this."

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.

At this inspection we found a more consistent approach to recording that people had consented to their care and where they were unable to, that MCA processes had been followed. A new care records format was being rolled out. The care files we checked had assessments of capacity and records that evidenced decisions were made in the person's best interest when it was decided they lacked capacity. We also found these had been completed in relation to the use of equipment that restricted people's movement, such as bedrails and to support any covert [hidden in food] administration of medicines.

We saw from care records some people had appointed attorneys by way of a lasting power of attorney (LPA) or where people lacked mental capacity, had deputies appointed by the Court of Protection. We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of involving family members in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

People we spoke with told us staff always sought their consent prior to assisting them and we observed this in practice during the inspection. They explained the support they were going to give in a way that people could understand and we saw people responded positively to this approach.
Staff understood people had the right to refuse care and in such situations, they would always consult with senior staff for further support and advice.

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). 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. At the time of the inspection, 13 people had a DoLS in place and the registered manager had made a

further 15 applications to the local authority, which were awaiting assessment and authorisation. We found the acting manager had followed up applications with the local authority to check on their status. This meant the registered provider and acting manager were acting within MCA legal framework.

Staff confirmed they received sufficient training to enable them to feel confident when supporting the people who used the service. The training records showed staff completed a range of essential training and courses about people's individual needs and conditions. Staff received supervision meetings with their line manager to identify training, support and future development needs. The acting manager explained how some staff had not received their supervision in recent months, but this had been addressed and a new programme had been put in place. The majority of long term staff had received an appraisal in 2016. Staff described improvements with the training programme, a more supportive working environment with the acting manager working alongside staff, good staff morale and a positive team approach. The continued development of staff ensured the care they provided was effective and in line with current best practice guidelines.

People's health needs were met. We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, community nurses, tissue viability nurses, speech and language therapists, dieticians and dentists. We saw the advice of external health professionals was incorporated into plans of care for staff to follow. Feedback from visiting professionals was mostly positive, comments included, "Staff support our visits well. We are happy with the care of our patient's here. Staff follow directions well and have a positive approach to any changes in care needed" and "Referral and liaison with our team is very good, although some staff seem less engaged with initiatives, such as exercise programmes." The acting manager confirmed she was aware of some inconsistent approaches from some staff which she was following up.

We found people's nutritional needs were met. We observed the breakfast, lunch and tea time meals and saw people were given time to eat their meals. They were shown different meals to help them make their meal choice. When people required assistance or prompting to eat their meals staff sat with them and encouraged them to take an adequate diet. People had access to a range of adapted utensils and plate guards in order to help them eat their food independently.

Hot and cold drinks and a range of general and fortified snacks were offered to people throughout the day. The range of snack meals had improved since the last inspection. Menus were reviewed regularly and the cook confirmed people were consulted about this to ensure their preferences were met. More fish dishes, casseroles and steamed puddings with custard had been requested and included on the spring menu. The cook also showed us the new photographs of meals they had obtained to assist people to make their meal choices.

Records showed staff had assessed people's nutritional needs on admission and weighed them in accordance with their risk management score. This meant some people were weighed weekly and others monthly. Care records showed the service referred people to a dietician or speech and language therapist if they required support with swallowing or dietary difficulties. The cook explained how they fortified foods for people who were at risk of losing weight and provided soft and textured diets for people with swallowing difficulties. We found people's fluid and food intake was monitored if staff felt people were not taking an adequate diet or had experienced weight loss. Throughout our inspection we observed the staff team made sure there was always a range of hot and cold drinks available to people to prevent them from getting dehydrated.

We found the building was suitably adapted for people who used the service. We saw there was good signage throughout and memory boxes were provided on each person's door which reflected their interests, working life and people important to them. New pictures, prints and sensory objects were arranged thoughtfully on corridor walls and were interesting to look at and to touch as well as having some reminiscence value. There was a good use of colour contrast on doors, handrails and bathroom fittings to support orientation for people living with dementia. Improvements with the garden were in progress, a new wooden gazebo had been erected to provide more shade and more planting was planned in the raised beds to provide more visual and sensory stimulation.

Good

Is the service caring?

Our findings

People who used the service told us staff spoke to them in a kind way and looked after them well. They confirmed staff respected their privacy and promoted their dignity. Comments included, "Fantastic staff, really good", "Very obliging, I haven't met one yet that I haven't taken to", "Very caring, only got to ask, if they can't help they will get someone who can." One person we spoke with mentioned that they felt some staff rushed them during their personal care. We passed this to the registered manager to follow up.

Relatives told us, "Staff are a friendly bunch, smiling and speaking to us, they do their very best, we have a good rapport", "The staff are kind, considerate, well humoured and well presented. They always explain what they need to do and ask us to step out of the room if supporting with personal care. We are consulted about our family members care" and "The staff all seem very caring, we are very happy with everything here."

Visiting professionals commented positively on the staff team. Comments included, "I've observed positive interaction between the care staff and the residents" and "Staff have a strong sense of resident advocacy, they want what's best for the residents here."

We found people were cared for by a stable staff team who knew them well, which gave them continuity in their care delivery. Staff were able to describe the ways in which they got to know people, such as talking to them or their relatives and reading their care files, which included information about people's preferences, their likes, dislikes and life history.

Staff described to us how they preserved people's privacy and dignity by knocking on bedroom doors before entering, closing doors and curtains while providing personal care and speaking to people about things quietly, so they could not be overheard. A care worker told us, "We always ask people about their care and listen to what their requests are. If it's safe to leave people in the toilet or the bathroom we will respect their choices." People looked well presented and cared for. Staff discreetly helped people to maintain their appearance, for example, by changing clothes if they became marked and stained. We saw staff sat with people whilst completing care and support paperwork. This enabled staff to provide people with social interaction, supervision and companionship at the same time as completing important paperwork.

We observed how staff interacted positively with people and took the time to speak with them in a friendly and approachable manner. Staff communicated well with people and listened to them, making eye contact and waiting patiently for their reply. Staff took prompt action to calm any distress and used a mixture of verbal and non-verbal communication techniques to comfort people. For example, when one person became upset and agitated a member of staff spoke with them in a reassuring manner, held their hand and encouraged them to sit with them and have a cup of tea. The person settled and sat chatting with the member of staff about their family and the singer that was due to visit the service later that day.

We saw people were offered choice, such as where they spent their time, meals and what activities they took part in. At lunch on the first day, one person asked to be moved to sit somewhere else, we saw staff

supported them to sit on another table and took time to check they had settled and were happy.

During the inspection we saw numerous visitors coming to see people who used the service. Staff took time to engage with people and their relatives in a pleasant and warm way, it was clear they had developed positive relationships with them. The acting manager informed us there were no restrictions placed on visiting times and the service actively tried to involve people's families in their care whenever possible.

Staff supported people to retain as much independence as they were able and wanted to. Some people were admitted for short stay re-ablement support and community therapists provided appropriate equipment provision and developed programmes to direct staff on maximising the person's independence.

Staff said they had received support and guidance from the acting manager about how to correctly manage confidential information. They understood the importance of respecting the privacy of people's information and only disclosed it to people such as health and social care professionals when they were required to do so. A member of staff told us, "We know not to talk about any aspect of our work outside the home."

We saw a range of information was provided in the entrance hall and on notice boards in corridors for people who used the service and visitors. This included information on how to keep safe, dignity awareness, activities and how to make a complaint. If people wished to have additional support to make a decision they were able to access an advocate. The acting manager told us that no-one was using these services at the time of our inspection.

Good

Is the service responsive?

Our findings

People who used the service told us they were satisfied with the care support, participated in activities and could speak with staff if they had concerns. Comments included, "I do exercises and baking - I believe in joining in. There's enough [activities] on", "I like the music" , "They have always asked me about my care, I can't praise them enough", "I would tell the manager but no complaints" and "I would tell one of the senior staff, but I can tell anyone as they are all good, staff are so willing to help, I have no complaints."

Relatives told us, "Our family member's health needs are very well met. They have been on an 'end of life' plan, but have defied this thanks to the staff", "Staff always ask [Name of family member] about their care, we have a care plan meeting every so often, they make changes for them", "We have raised small concerns and these have been dealt with quickly", "Yes, I have made a complaint and all issues were dealt with satisfactorily" and "Lots of activities, the co-ordinators are excellent and provide a lot of one to one support too."

At the last inspection on 26 and 28 January 2016 we found some people's needs had not been fully assessed and some care plans did not provide clear guidance to staff in how to support people's specific needs. Care plans had not been updated when people's needs had changed. This meant there was breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice. At this inspection we found the necessary improvements had been made.

We saw detailed assessments of people's needs were completed before they moved into the service. These contained a range of information, for example, how staff would need to support the person to maintain a safe environment, how the person communicated their needs, nutritional concerns, mobility, continence, sleep pattern, personal hygiene and dressing. There were also risk assessments to identify specific areas of concern. We found these had been completed accurately and they were linked to the care plans. Assessment information for people admitted for short term re-ablement support was provided by the relevant nursing team and the care management team where possible, prior to admission. The acting manager confirmed some people were admitted during the night, as an emergency and assessments were then completed following admission.

A new care recording system had been provided and 50% of the care records had been rewritten onto the new format. The format was more user-friendly and comprehensive. We saw people's care plans contained more detailed information to meet their individual needs. They were person-centred in the way they were written. We found the care plans gave a clear picture of people's needs and abilities, so staff knew the level of support the person required and could enable them to maintain their independence. The acting manager confirmed they would also be reviewing the format of the records for people admitted for re-ablement support. The majority of the plans were evaluated on a regular basis or as people's needs changed. We found two new style care records had not been evaluated since they were rewritten some months before and these were completed during the inspection. Supplementary records such as food, fluid and repositioning records were well completed and maintained.

We saw information was gained in a timely way from relevant healthcare professionals and advice was acted upon to help maintain people's wellbeing. Clear behaviour support plans were in place which informed staff on the preferred strategies to use to reduce anxiety and keep people safe, if people displayed behaviours that challenged.

We saw staff responded to changes in people's health needs and provided effective care. We observed staff acted quickly when a person became unwell and they arranged for the person's GP to visit. During the evening meal a person experienced a fall in the dining area, we observed staff responded quickly to provide effective support and reassurance to the person.

The registered provider employed two activity co-ordinators who supported people with a range of individual and group activities for six days each week. We observed the staff interaction and engagement with people was positive, people responded to their approach and they enjoyed spending time with them. Group activities ranged from music afternoons, exercise groups, quizzes, games, Bingo, crafts, baking, gardening and trips out.

Other activities people enjoyed included a singing session with visiting entertainers, dog therapy, reading, crafts, dominoes, manicures and painting. One of the activity co-ordinators described how they had completed a variety of courses in activity provision. This included one provided by the National Association for Providers of Activities for older people (NAPA). They explained how they were working with people and their families to complete scrap books to support the 'This is Me' personalised records in the care files about people's backgrounds, families and interests. Volunteers also visited the service regularly to spend time talking with people and supporting with activities. During the inspection we observed colouring activities were left out on tables and people were supported to take part in a sing-a-long, balloon games, dominoes, snakes and ladders, watching films and a singer visited.

The acting manager described how music therapy was being used at the service with the aim of calming people who were unsettled. Some people had headphones and relatives had been consulted and recommended various singers or pieces of music they knew their family member liked or responded to. The acting manager explained how one person had the Wedding March on their play list and loved listening to this.

The registered provider had a complaints policy and procedure in place to enable people to raise concerns. We saw complaints information was available for people and described timescales for acknowledgement, investigation and resolution. There were details of where people could escalate complaints if they were unhappy with the outcome of an investigation. Staff knew how to manage complaints. Records showed that when complaints were received the registered manager had followed the registered provider's policy to ensure the issues were managed appropriately and resolved.

Requires Improvement

Is the service well-led?

Our findings

People who used the service and relatives considered the service was well-managed. One person said, "I think this [the service] is the best one." Another person said, "I go to the resident's meetings, they ask if we want any changes, I enjoy being here." Comments from relatives included, "Now the new manager is in control yes, she is putting things in place", "The new manager seems very good at her job. The service is much calmer when we visit and the staff don't seem so busy and stressed" and "The manager is always very pleasant and accommodating."

We found there had been five occasions when the Care Quality Commission (CQC) had not received safeguarding notifications of incidents that had occurred between people who used the service in recent months, although they had been reported to the local authority. We had received reports of other notifiable incidents such as when people who used the service died, when they had a serious accident and when the local authority authorised a deprivation of liberty safeguard. The acting manager told us this had been an error and in future the CQC will be notified all safeguarding incidents when they occur. It is important we receive notifications for these incidents so we can monitor the amount of them and check with the acting manager how they are supporting and protecting people.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations and on this occasion we have written to the registered provider reminding them of their responsibility regarding notifications to CQC.

The service had undergone management changes in 2016. The registered manager had left the service in December 2016 and the operations director(acting manager) had taken over the day-to-day management responsibility and their registration to manage Fairways Care Home had been completed with CQC on 13 March 2017.

We spoke with the acting manager about the culture of the organisation. They explained their focus in recent months had been to promote a more person centred ethos and they had worked closely with staff to monitor the quality of care. Improvements had been made with care delivery, the management of the shifts, daily routines and the quality of care records. The acting manager had also spent time with people who used the service, their friends and families promoting a more visible management approach and effective communication systems.

In discussions, staff told us they felt supported by the acting manager and were able to raise concerns; they said they enjoyed working at the service. The staff described improvements with the overall management of the service in recent months. They told us, "[Name of new manager] has a different management style and the residents and staff have all benefitted from this. The home is much calmer, respite admissions are better arranged and staffing has improved" and "The manager is much more visible and supportive, they are out on the floor observing care and assisting us when necessary. Very approachable."

There was a range of processes in place which enabled the registered provider and acting manager to

receive feedback on the quality of care provided at the home, this included regular meetings and satisfaction surveys for people who lived within the home and their relatives. We saw the results of recent consultation were published on the notice board in the entrance area, entitled 'You said-we did'. Information requested and provided included the balance of the residents fund and the numbers of carers each shift. Confirmation that access to the garden through the lounge door had been secured and a cinema room provided, where people and their relatives could sit and enjoy films.

Regular meetings were held with staff in all of the job roles within the service including care staff, housekeeping, administration and catering staff. This meant information could be shared effectively across the team. Records of the meetings showed subjects such as safeguarding adults, feedback from surveys, progress with action plans, changes with rotas, standards of care, records management and training were discussed. A care worker told us, "Yes, we have regular staff meetings. The manager listens to us and we are able to have our say. The handover meetings provide detailed updates about people's care and if there have been incidents such as falls."

A range of audits and checks were undertaken by the senior management team. We found aspects of the quality monitoring programme had been reviewed and strengthened since the last inspection. More detailed processes to audit incidents had been introduced and records showed appropriate analysis of the findings and further action had been taken to protect people's safety. For example, decisions had been made on the use of equipment and sensor devices for some people. Regular audits of other areas included nutrition, the kitchen, housekeeping, infection prevention and control, dignity, end of life, health and safety, staff training, call bell response times and complaints. Where shortfalls had been identified these had been addressed through action planning.

We found that audits of care records had not been completed since April 2016 when the work to introduce the new care records format had commenced. There were no audits of medicines carried out after August 2016. An external audit had been completed by a pharmacist contracted by the local clinical commissioning group in February 2016 and some of the findings mirrored those found during this inspection. In response to recent concerns and audit findings, the acting manager confirmed they were in the process of changing the type of monitored dosage system which would provide the medicines in individual 'blister packs'. They were also arranging further medicines training for staff and would be delegating the lead role in medicines to one of the senior care staff, which would provide more continuity and oversight of the management systems. Weekly audits of the medicines systems had commenced following the inspection.

Reviews of the service were also carried out by a nurse consultant contracted by the registered provider. This review visit included discussions with staff, people who used the service and checks on all the management and administration systems. The last review was completed in September 2016 and made 49 recommendations, the majority relating to shortfalls found in the care records reviewed. During our inspection we found evidence that these had all been addressed and those care records had been transferred over to the new format. The acting manager informed us that the registered provider had recognised there were still inconsistencies and limitations with the existing quality monitoring systems and these needed updating. They had obtained a new comprehensive auditing system which would be implemented over the next few months and there would be more regular external quality reviews carried out by the nurse consultant.

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 The registered person had not ensured people who used services were protected against the risks associated with unsafe management of medicines.