Strathmore Care

Fairview House

Inspection report

14 Fairview Drive
Westcliff On Sea
Essex
SS0 0NY

Tel: 01702437555
Website: www.strathmorecare.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Fairview House provides accommodation and personal care for up to 55 older people and older people living with dementia.

The inspection was completed on 26, 27, 31 October 2016 and 2 November 2016 and was unannounced. There were 48 people living at the service when we inspected.

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.

Immediate concerns and risks to people's health were identified by us during inspection. A lack of leadership and managerial oversight meant that the service had failed to identify risks to people and staff and had the Commission not intervened the risks would likely have remained. The provider responded immediately to the Commission's requests for urgent action and further provided an action plan to drive improvements throughout the service.

Quality assurance checks and audits carried out by the provider were not robust, did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised. Although some systems and processes were in place they were not being used effectively or at all to ensure robust quality monitoring of the service.

Suitable control measures were not always put in place to mitigate risks or potential risk of harm for people using the service. Care records and risk assessments had not been updated for all areas of identified risk and pressure mattresses were not correctly set in relation to people's weight. The management of medicines was not always safe and improvements were required to staff's practices and procedures to ensure these were in line with current legislation and guidance.

Assessments regarding people's individual decision making were generalised and not decision specific. Not all care workers were able to demonstrate a good knowledge and understanding of MCA and DoLS despite having received training. Arrangements for the use of covert medication were poor and 'best interest' meetings to evidence decisions had not been considered.

Relatives' reports regarding staffing levels were varied and we judged that there were not sufficient numbers of staff available to meet people's needs at all times. Our observations showed that staffing levels and the deployment of staff were not suitable during the entire inspection. In addition, the majority of interactions by staff were routine and task orientated and improvements were required. The provider responded to our concerns and reviewed staffing levels and implemented contingency plans should staffing levels fall below the assessed minimum level of staff.

Whilst some staff's interactions with people were positive, this was in contrast to other observations where we saw some staff's practice when supporting people required further improvement and development as they displayed a lack of regard for people's privacy at times and did not always have due respect for people.

People's care and support needs had not always been documented as required and reflected in their care plans. Improvements were required to ensure that the care plans for people were detailed accurately to ensure staff had adequate information to support people. Although people knew how to make a complaint or raise a concern, records showed that complaints had not been responded to in line with guidance.

Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability. The provider advised us this had been addressed and an activity co-ordinator had been recruited.

Systems were in place for newly employed staff to receive an induction. Although arrangements required improving to ensure that formal supervision and appraisal measures were in place. Although care staff had largely completed mandatory training their knowledge was not adequately embedded in order to apply it to people's needs effectively. Competency of staff in charge was not formally recorded however plans were in place to address these concerns. The provider's recruitment procedures were adequate so as to safeguard people using the service.

The dining experience for people was positive for people with independence. Although reports from relative's regarding meal times were not always positive on behalf of those requiring more support. This was also the case regarding accessing appropriate healthcare services.

You can see what actions we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Immediate risks to people and staff had not been foreseen by the service; this was immediately rectified by the provider, however, without identification and intervention from the Commission these would have remained.

Improvements were needed to the deployment of staff to ensure appropriate support at all times. Following our inspection staffing levels had been adjusted to accommodate better overall support of people.

Risks to people and staff were not always appropriately managed or mitigated so as to ensure safety and wellbeing of all.

The management of medicines was not always safe. This referred specifically to the administration and recording of medication.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were required to ensure that appropriate arrangements were in place for staff to receive formal supervision and an appraisal.

Although staff had received training some care workers knowledge was not robust to in order for them to apply it to their duties effectively.

The arrangements for the use of covert medication were poor and 'best interest' meetings to evidence decisions had not been considered.

The dining experience for people was positive for those with increased independence. Those with support needs did not consistently receive appropriate support.

The environment required improvements to aid people's individual needs, particularly for people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

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.

Staff were not always mindful of people's privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

People were not always engaged in meaningful activities or supported to pursue pastimes that interested them and improvements were required.

Complainants were not responded to adequately with regard to concerns and complaints raised.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and managerial oversight of the service as a whole. The provider's systems to check the quality and safety of the service were poor and risks that we found had not been identified.

People and their relatives were provided with limited opportunities to be involved in service improvements. When feedback from people was gained the service had not consistently responded adequately to concerns.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service, including safeguarding alerts and other notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

This inspection took place on 26, 27, 31October 2016 and 2 November 2016. The inspection was unannounced and the inspection team consisted of two inspectors on three days of the inspection.

Several people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. Therefore on 2 November 2016 we spoke with relatives of people who use the service as part of our ongoing inspection. 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 four people who used the service, eleven members of care staff, eleven relatives, district nurses, the training co-ordinator, acting manager and provider.

We reviewed five people's care plans and care records. We looked at the service's staff support records for nine members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

The service had not ensured that there were sufficient numbers of suitable staff to keep people safe and meet their needs. During our inspection we had concerns about the amount of staff available to meet people's care and support needs. The acting manager and provider advised us that the minimum number of care workers needed was 9 on the morning shift (08:00 – 14:20), 9 care workers on the afternoon shift (14:00 – 20:20) and 4 care workers on the night shift (20:00 – 08:00). The acting manager told us they were also available on site to assist with people's care needs every day.

Daily work plans were provided to us that indicated how staff were deployed across the service each shift. These documents revealed that between 20 October 2016 and 26 October 2016 eight morning and afternoon shifts had dropped below the minimum number of care workers the provider had deemed adequate to support people. Daily work plans also revealed that two night shifts in October 2016 only had three care workers on duty.

Our observations reinforced our judgement that staffing levels were not always adequate. We observed over a period of 30 minutes that there were no care workers in the main lounge where most of the people were, as they were either supporting people with personal care or medication. On another occasion we observed on the ground floor, for 50 minutes, one lone care worker interacting minimally with people and completing paperwork whilst facing away from the majority of people. Therefore we observed 14 people sitting between three lounges and a dining room and a further 2 people wandering between the garden and the dining room with the support of only one care worker. The layout of the ground floor did not allow for all areas of the ground floor to be observed by one care worker. One person had climbed up on a dining room chair in an to attempt to shut a high window for themselves; it was only once the person was on the chair that the one care worker in the area noticed and then proceeded to support them safely off the chair.

We saw written complaints from relatives and enquiries from local authorities regarding concerns of inadequate staffing levels. Relative's views on staffing levels were mixed when we asked them. One person told us, "There always appears to be enough staff." Another person told us, "Sometimes they are good and sometimes they are very short staffed. [Relative's name] has to wait a long time for help going to the toilet, especially at hand over time. Had to wait nearly an hour today for someone to help."

Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us staffing levels were inadequate to meet people's needs and that this could be stressful, especially when the home was at full capacity. One staff member informed, "It's normally very busy and hectic in here, but I think because you (The Commission) are here we have more staff on shift. There's normally between 7 to 9 staff and that's including the seniors but today there are 12 I think." Another care worker told us, "Days, afternoons and nights are all poorly staffed. We are supposed to have 2 people in the lounge but a lot of the time we are left on our own so can't help people go to the toilet as you can't leave the floor." On the afternoon of the first day of inspection we observed that there were only 7 care workers on shift to support people.

During the inspection we were not assured by the acting manager or the provider that staffing levels were regularly or adequately assessed. The acting manager reported to us that they informed the provider of the number of people living in the service each day. However they could not tell us how people's dependency levels helped determine the number of staff required to support people adequately. The acting manager advised us that the provider determined the staffing levels at Fairview House. We discussed the importance of the acting manager being aware of people's changing dependency levels in order to respond appropriately and dynamically with the correct staffing levels.

In response to our urgent action letter dated 28 October 2016 the provider did answer our concerns over inadequate staffing levels and provided documentation to evidence how levels are determined based upon the dependency needs of people. However, we were not assured that the environment of the service or special assistance such as, challenging behaviour or moving and handling was taken into account adequately. For example, one trainee senior told us that on the night shift between inspection dates they had deemed it necessary for a care worker to accompany one person to hospital. This left one trainee senior and two care workers on duty. When two care workers provided personal care to one person that left one care worker to monitor over 40 people across three floors alone. The acting manager agreed during inspection that four care workers on the night shift was not adequate for the safety of people and staff and that staffing levels should be reassessed. However, after the inspection the provider confirmed that four staff on night shifts were deemed safe in normal circumstances.

These shortfalls were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we met with the provider's representatives who assured us that they would implement safety contingency plans at night to ensure staff knew what to do in an emergency and who to call to support should they require additional staff support.

Medicines were not consistently managed safely. Although people and relatives told us medication was received as they should be and at the times they needed them, the management of medicines within the service required improvement. Whilst medicines were stored safely for the protection of people who used the service, we found a number of discrepancies relating to staff's practice and medication records. We observed in one person's room 4 loose tablets on the person's over bed tray. The Medication Administration Record (MAR) had been completed and signed by the senior on duty to verify that medication had been taken by that person. We discussed this with the senior on duty and they acknowledged that they had completed the MAR incorrectly and confirmed that they thought the person had taken the medications and knew they should be observed to make sure their medications had been taken. The senior responded appropriately and disposed of the medication safely and amended the MAR and recorded that the medications had been omitted.

Weekly medication audits were not carried out. Although a systems and process was in place to carry out weekly medication audits we saw that the last robust audit had been completed on 1 May 2016. The acting manager was unable to provide a rationale as to why this lack of monitoring had occurred.

Staff involved in the administration of medication had received training. However competency checks to ensure that staff who administered people's medication remained proficient had not been completed at regular intervals or at all. For example, the training co-ordinator confirmed that trainee seniors not been formally assessed to confirm that their medication practices were appropriate or safe. Trainee seniors had been repeatedly appointed as the person in charge during shifts. The training co-ordinator told us, "Seniors have to be observed as competent as well as carry out training and complete the 'Development Programme

for the Administration of Medication' workbook." They explained that although the trainee senior hadn't formally been signed off as competent, they knew their practice was safe by informal observations. The training co-ordinator responded immediately to our concerns and completed the competency of one trainee senior's medication administration during the second day of inspection. They also showed us a matrix they had created to ensure all seniors were scheduled to have their competency checked regularly.

We found that appropriate arrangements were not consistently in place to manage risks to people's safety. Staff knew the people they supported and risks to most people's health and wellbeing, for example, the risk of falls, poor mobility and the risk of developing pressure ulcers. However in some instances risks had not been documented in care plans adequately and where risks had been identified, suitable control measures had not been put in place to avoid risk or potential risk of harm for people. For example, one person's care plan, which had been reviewed on 30 September 2016, stated that they could 'walk the stairs independently.' However, we saw documentation in their care records dated 10 August 2016 that stated they needed 24/7 monitoring for her health and safety and can use the stairs with the assistance of one care worker. This meant that should an unfamiliar staff member such as an agency person read the care record without any other knowledge of the person's abilities they would be at risk of falling and potentially injuring themselves.

Additionally, we saw two people walking around inside the home and out in the garden grounds together. On two occasions we observed that one of these people had picked apples from a tree in the garden grounds and eaten them. No care workers were aware or witnessed this person's actions. The person's care records informed us they had a health condition for which correct nutrition was important. Additionally, the apples had not been deemed suitable for consumption. When we spoke to the acting manager and care workers about this they confirmed they were not aware this action had taken place during inspection. However one member of staff did inform us that sometimes morning care workers will find a number of apples in the person's room and will remove them as they would have not been cleaned or suitable for consumption. Risk assessments had not been created to help avoid risk to this person.

Some people were assessed as at high risk of developing pressure ulcers. We checked the setting of pressure relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating and found that two out of three viewed were incorrectly set in relation to people's weight. For example, the pressure mattress setting for one person was fixed on setting eight and this was for a person who weighed 160 kilograms; however their weight records detailed that in October 2016 they weighed 48.3 kilograms. This meant that we could not be assured that the amount of support the person received through their pressure relieving mattress was correct and would aid the prevention of pressure ulcers developing or deteriorating further. The provider and staff confirmed that no records were in place to monitor that pressure relieving equipment had been set correctly. We also found that people were required to have their body repositioned at regular set times so as to relieve pressure from an existing pressure ulcer, and to prevent the development of pressure ulcers. We viewed records which indicated people were not being repositioned as directed in people's care plans. For example, the instruction for one person stated that they should be repositioned throughout the night, three hourly, for pressure area relief. Repositioning charts showed that there were two days whereby the person had remained on their back for over 24 hours. We were not assured that risks to individuals were managed adequately so that people were supported safely.

During the inspection we were told by staff that three moving and handling hoists had been out of service for approximately one month, which had left them with two working hoists. The lift had also been out of order since 19 October 2016. As a result staff told us they had been carrying the hoists up and down flights of stairs in order to meet people's transfer needs. This was not safe practice for staff which put themselves and people at risk. The acting manager had not taken immediate steps to mitigate risk to staff and people or

resolve the shortage of hoists.

We also observed during our inspection that internal doors and emergency exit doors leading directly onto stairwells were not made secure or assessed appropriately for risk. For some people access to stairs, unaccompanied, was a major risk and one that had not been managed by the acting manager or provider. We urgently requested the provider's response in regards to the lack of hoists and unsecured fire exits, they responded immediately by making doors secure and ensuring hoists were sourced on the same day. However, had the Commission not identified and intervened to ensure immediate actions were taken; people and staff would have remained at risk.

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

An effective system was in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Staff files we looked at contained adequate recruitment documentation. 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). Staff we spoke with told us they had interviews and supplied all the relevant documents before starting work at the service.

People reported to us that they felt safe living at Fairview House. Relatives also told us that they felt their relatives were safe at Fairview House. One person told us, "I know the staff are kind and look after everyone well; there's just not enough of them."

Care workers were knowledgeable of the signs of potential abuse and the service had a policy for staff to follow on safeguarding and whistle blowing. The staff consistently told us they knew they could contact outside authorities such as the Care Quality Commission (CQC) and local authorities. The acting manager and provider had a good understanding of their responsibility to safeguard people and knew how to make referrals to the local safeguarding authority to investigate if they needed to raise concerns.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received an effective induction over two weeks depending on their role and responsibilities. This included an induction of the premises and training in key areas appropriate to the needs of the people they supported. Care workers also confirmed that the induction had included opportunities where they shadowed a more experienced member of staff. This was so that they could learn how to support individual people effectively and understand the specific care needs of people living in the service.

Staff training records showed and staff told us that they had received suitable training to meet the needs of the people they supported, through 'in-house' or via the Local Authority. However knowledge was not embedded in their everyday practice. Several people were living with dementia, some in the early stages of the condition whilst others were living with more advanced dementia. Although staff told us they had received training relating to dementia, we found examples of poor staff practice which indicated a lack of understanding and application of the learning from training provided. Some staff did not demonstrate an understanding of how to support people living with dementia and how dementia affected people in their daily lives. For example, some staff did not communicate effectively with individual people or provide positive interactions. We observed one person call out "Nurse, Nurse, please help me Nurse", one care worker walked past the person and it was only a few minutes later when another staff member came into the lounge that the person was responded to. This showed us that the training provided had not equipped all staff to communicate effectively with people living with dementia or those that had communication difficulties.

Understanding of moving and handling equipment varied between care workers. Senior care workers spoke confidently about moving and handling practices. However lesser experienced care workers expressed their lack of knowledge, "We were told to look at them [people] to assess what sling to use with the hoist. We find out more working on the job and watching others than through the training." Another care worker told us the different coloured slings related to the gender of the person. Although we did not see unsafe moving and handling practice, discussions with some care workers revealed they did not have the knowledge to carry out their roles and responsibilities effectively.

Competency of staff had not been regularly assessed to ensure continued safe practice. One training co-ordinator told us, "I want to provide staff with support and guidance, my aim is to observe the competency of staff formally three times a year, but I have only just started this process." We were shown a document created during inspection which detailed scheduled dates for each member of staff's competency check.

Documents revealed that since the middle of 2015 the majority of staff had not received regular supervision and appraisals. Staff informed that there was not always enough time in the day for formal supervision to be undertaken. One care worker told us, "I get feedback informally from [training co-ordinators name] but no real supervision." In addition, staff did not see the value of supervision as they felt that issues raised in previous supervisions had not been addressed or dealt with effectively. This included issues relating to staff practices, relationships and communication. For example, most staff we spoke to informed us there were

unsettled relationships between the seniors, management and care workers. Care workers informed us, "As carers we work well together, but the seniors never really support us or are willing to listen to us when we make suggestions." and, "Often we go straight to one of the owners to discuss our concerns and they are always willing to listen."

These shortfalls were a breach of regulation 18 of the Health and Social Care 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. 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 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. The acting manager had an understanding of the principles and practice of the MCA and DoLS. The acting manager informed us that they worked hard to ensure that people's needs and rights were respected. Appropriate applications had been made to the local authority for DoLS assessments.

However, 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 MCA and DoLS despite having received training. Staff did not understand the legal requirements of the MCA. We found mental capacity assessments on day to day decision making to be generalised on the basis of people's cognitive impairment diagnosis. For example, people had been deemed not to have capacity to make any day to day decisions due to them having dementia. Each individual's specific need and ability to consent to specific activities and tasks had not been assessed, for example, what clothes they would like to wear, where they would like to eat their meal, choice of food or if they understood what medication they took and why.

We found that the arrangements for the administration of covert medication for one person using the service were not in accordance with the Mental Capacity Act (MCA) 2005. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink. Although there was evidence to show that the person's GP had agreed for some of their medications to be crushed, the acting manager or provider had not instigated a 'best interest' meeting with all necessary parties involved, for instance, the pharmacist who should have been consulted to agree a management plan and to ensure that the properties of the medication remained effective once mixed with food or drink and ingested. A management plan had not been completed to confirm that this decision was in the person's best interest and the least restrictive option. The acting manager responded to concerns and told us they would liaise with all relevant parties to ensure actions carried out were in the person's best interests and documented appropriately.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always met in a way personal to them or in a way that would ensure their safety and wellbeing.

The kitchen staff were unaware of everyone's specific dietary requirements. The cook told us, "We only have people on fortified diets, one vegan, one vegetarian and one person who doesn't like fish. No-one has any allergies." However they did not know which people were on specific diets such as textured/soft diets and told us they relied on the care workers to tell them who has their food pureed. The acting manager and provider addressed this concern immediately when we discussed it with them and provided kitchen staff with current information of people's specific dietary requirements.

People with independence regarding food were positive about their dining experience. However, findings were not consistently positive with regard to people who required more support with eating. One relative told us, "The food is good but half of it ends up on the floor because [person's name] can't see it. [Person's name] needs more support at mealtimes." Conversely, people we could speak with were positive about the meals provided. One person told us, "Food and drink is adequate, I can ask for more and they give it to me." Another person told us, "Yep, food is nice." A relative told us, "The food is delicious here, [relative's name] has been worried about putting on weight the food is so good here." Throughout the inspection people were provided with sufficient drinks at regular intervals.

People's care records did not consistently show that their healthcare needs had been recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. For example, one care worker had written in the communications book that one person required to see their social worker regarding increasing aggressive behaviour. The person's relative told us, "We need [relative's name] social worker involved." The acting manager told us they had attempted to contact the social worker several times but had no response. It was unclear from records what action had been taken and what further action was planned to involve the necessary healthcare professionals.

People who were able to communicate effectively told us their healthcare needs were supported. One person told us, "I have noticed I had red areas on both my legs, I think it's from the bed. They [care workers] called the district nurses who came to sort it out. They put cream on now." A relative told us, "When [relative's name] has had a fall or are taken to hospital they [care workers] are so caring, they let us know straight away and go with them to hospital until we get there." Two district nurses we spoke to during inspection told us that staff at Fairview House always alerted them to needs of people.

The environment at Fairview House did not safely facilitate everyone's needs and wellbeing. The layout of the ground floor is extremely spacious and people have the choice of sitting in various lounges and dining room. However, there were not enough staff to safely observe the people in all these areas. The grounds of the garden were uneven in places, posing potential risks to people who accessed the garden. Additionally we observed people walking down corridors looking closely at small printed names on doors trying to find where they wanted to go. The corridors within Fairview look identical which posed a problem for people living with dementia. One care worker told us, "I realise the environment could be improved. Maybe the walls could be painted in different colours to help people identify where they are and decorate their front doors with something they recognise." The rooms looked very tired and old. One relative told us, "[Peron's name] room looks a dump, it's not nice aesthetically."

The lift within the service had caused negative impact on people's wellbeing as it had been out of service for a considerable time. One person emotionally told us, "People are pleasant here but it feels like I'm trapped. It's worse since the lift has broken. I want to get out of this box." The provider told us that the lift was fixed on 4 November 2016. Additionally we were told at the meeting with the provider that plans were underway to upgrade the current lift and install a second lift within the service.

Requires Improvement

Is the service caring?

Our findings

People's comments about the care and support they received were generally positive. People told us, "Staff are mainly alright, some are exceptional but no-one is awful;" and, "I have every praise for the staff here." A relative told us, "The carers are always friendly to everyone here. I have no concerns we wouldn't be here if I did." Another relative spoke kindly of the care workers and how they had helped the whole family through the death of a family member.

Although people and their relatives told us staff were caring and kind, our observations showed this was not always consistent. In one instance although we saw that the care worker was not outpacing the person when they were supporting them to eat, there was no verbal communication between the person and the care worker during support. Where people were not able to communicate effectively staff interactions were limited in there frequency and not personalised, for example we observed two care workers talking about where to seat one person while they pushed them in their wheelchair. There were no discussions or interaction with the person about where the person might like to sit. We observed that on occasions staff spent time talking with each other rather than interacting with the people they supported.

Staff did not consistently support everybody in a respectful and dignified way. We observed the same person, within the same day, on three separate occasions walking around Fairview House with soiled trousers. We observed one care worker playing a game and interacting predominantly with one person who could communicate whilst 12 other people sat in chairs with minimal interaction from others for approximately 40 minutes. Additionally, when we asked another person, who was bedbound, if the care workers responded to their call buzzer within adequate time frames the person told us, "I don't know, there is no clock in my room and my watch is set at the wrong time. I don't know what time of day it is."

People and relatives told us privacy was respected. One relative told us, "There are tea rooms that you can use if you want to have a chat in private. We have used them to celebrate birthdays privately which is nice." However we observed that one person's privacy and dignity was not respected as the care workers had not noticed that personal care being provided could be seen directly from the stairwell through their bedroom window. When one relative showed us the bedroom that their relative has been moved to we saw that there were A4 notices stuck onto the walls reminding care workers to perform tasks for an individual who had sadly passed away weeks prior to the room being allocated to someone else. The room was small and dingy and had no chair for visitors to sit. We observed the relative of the person trying to find a care worker to ask for a chair to sit on in the person's room. The acting manager responded to the concerns we raised immediately, however we were concerned about staff knowledge and the culture within the service in relation to providing people with dignified care and respecting them as individuals.

These shortfalls were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Advocacy information was displayed within the service. An advocate provides support and advice to people and is available to represent people's voice and interests. However, when we spoke to people and relatives

about who they would turn to should they need external support they had very little knowledge of who they would speak to. Similarly senior care workers and the acting manager had limited information when we asked them about the purpose of advocacy services.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care in a person centred way because the deployment of staff meant the service's approach to care was mainly task-led and routine orientated. This meant that interactions between staff and people using the service were primarily focused around the provision of personal care, drinks and meals. Additionally, only 3 care workers had completed person centred training. Care workers consistently told us that they didn't have time to read people's care plans and were reliant on receiving current information about people in daily handover meetings. We were not assured that robust systems were in place for staff who provided care to be kept up to date with any changes to a person's needs or preferences.

Care records were not reviewed by the acting manager. Therefore care plans we saw had not accurately been updated. For example, one person's mobility care plan stated they could safely walk stairs unaccompanied; this was not correct and records had not been updated. Another person's care plan stated they were on a normal diet, this was not correct as they were on a soft food diet. Behavioural charts, repositioning charts, hourly check records and fluid charts were not consistently recorded, monitored or reviewed to mitigate against the risks of poor practice or health needs. This lack of governance was recognised in a provider meeting in July 2016, however we identified that these concerns had continued. This further raised concerns that if care workers had not received a handover of people's needs for some time, care plans could not be relied upon for accurate information to support their needs. The acting manager assured us that care plans would be fully reviewed with input from health professionals. The provider also advised us that the acting manager would identify time in the duty rota to allow individual care workers 20 minutes to familiarise themselves with people's care records.

People using the service or those acting on their behalf had been involved in the initial care planning process or consulted. Relatives consistently confirmed that they had initially seen their member of family's care plan and had provided information as part of the pre-admission assessment process. However relatives told us they had not had any further regular involvement in reviewing the care plan unless significant changes had been made. One relative told us, "We initially had meetings about the care needed but have not had regular meetings since then. They [care workers] do call me up if anything changes." Another relative explained to us they had not been involved in regular reviews of the care plan and had been reliant on accurate care records in a review meeting concerning their relatives funding for care. They told us that their application for funding had been overturned due to inaccurate care records being maintained by the service.

Although appropriate arrangements were in place to assess the needs of people prior to admission, assessed needs were not always catered for. One person's care records stated that they had a very specific communication need. Although there was a document to instruct care workers how to attempt communication with this person, we found that none of the staff had received any training to effectively communicate with the person and we also did not see anyone attempt to use this person's preferred method of communication. Although the person could use limited other means to, they told us how they felt frustrated communicating sometimes. The person's relative explained to us how they felt the care workers may not have the knowledge or the time to face their relative directly and communicate with them which is

why the person felt frustrated. The lack of communication with the person had affected their wellbeing.

People's preferences and choices for their end of life care were not recorded. Preferred Priorities for Care [PPC] documents were not in use. This is a document designed to help people and their relative's prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life. This meant that people's 'end of life' wishes were not recorded, in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The PPC would facilitate a more individualised approach to 'end of life' care which is a joint approach used by all professionals involved in a person's care that would ensure they received appropriate and co-ordinated end of life care.

The service did not respond to people's experiences appropriately. Staff told us that several people living at Fairview House had behaviours that may challenge due to their mental health; however care records did not clearly indicate how each individual could be supported when they became anxious. Documents were not used appropriately to enable staff to analyse and help improve people's levels of anxiety and wellbeing. Additionally only one member of staff had received training in 'challenging behaviours'. We saw in people's care records entries from care workers, in daily notes and reports of incidents on scrap pieces of paper detailing people's behaviours. Two people had been involved in incidences regarding exiting through fire doors which had caused risks to themselves. Although temporary plans had been put in place for one person a similar incident happened to them only one month later. The other person had moved rooms to ensure their safety. The person's relative told us they agreed to the decision at the time as the person's immediate safety was paramount. However responses to immediate risks were reactive and may not have been the most effective or robust course of action. There was no documentation to show why the incidences occurred, what the possible options were to mitigate risks, how incidences may be prevented in the future and who had been involved in the decisions.

Our observations throughout the inspection showed that there were few opportunities provided for people in regards to planned social activities. There was a lack of meaningful engagement and people were not supported to pursue their interests or hobbies.

The out of service lift had caused considerable negative impact on some people's wellbeing throughout the service for prolonged periods. We saw one person restricted to the first floor, due to the lift, knocking on every door saying 'hello?' and had made their way towards an unsecure exit leading to a stairwell. When we approached them they told us, "I'm bored, I just got put in the lounge and left, there's nothing to do." At the meeting with the provider on 9 November 2016 we were told that a contingency plan had been devised to address people's wellbeing should the lift break down again.

There were no activities in the afternoon on two days of the inspection. On the third day of inspection the care workers sang karaoke to the people living at the service, with little involvement from the people themselves. Relatives repeatedly told us about the lack of activities within the service. The provider did inform us that an activities co-ordinator had been recruited and would be working between Fairview House and a sister service. Nevertheless our observations throughout the inspection showed that there were few opportunities provided for people to join in with social activities.

Improvements were needed to ensure that all the people living at the service received support to engage in their favourite pastimes and live an active life. We found that people's care plans clearly identified their interests and likes in regards to social activities, however on looking at people's care plans and observations on the first floor it was not clear as to how people were being encouraged to have this need met. The provider informed us that there would be emphasis placed on developing meaningful activities for people

by finding out people's life history and incorporating their own personal skills around the home in person centred daily activities.

These shortfalls were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information on how to make a complaint was available for people to access. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff on duty. Relatives stated that they felt able to express their views about the service. We saw and relatives told us that they had raised concerns.

Although the complaints process was available and all felt able to use it, concerns and complaints raised were not viewed as an opportunity to learn or improve and not consistently recorded. The complaints file showed there had been three complaints from relatives between September and November 2016. Although a record had been maintained of each complaint and there was evidence to show that each one had been responded to, the responses did not consistently make sure that everything had been done to resolve the complaint in line with the service's guidance for complaint responses. I.e. explanations provided, mediation, practical action specific to the complaint. One relative told us, "They keep giving [person's name] a knife and fork but they can't use them I have to keep telling the staff this." The person's care plan had not been updated to reflect the needs of the person and the concerns raised by the relative could not be found by us in the complaints book.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

During inspection the lack of leadership was clearly demonstrated by the fact that significant health and wellbeing risks to people and staff had not been identified or acted upon. The provider responded to our immediate concerns and also provided action plans in response to a letter requesting urgent action. The action plan was robust however The Commission requested a further meeting with the provider on the 9 November 2016 to gain assurances that findings from the inspection were continuing to being addressed.

The provider's quality assurance arrangements and processes which assessed, monitored or improved the quality of the service was inadequate. Systems for improving the service through auditing and monitoring were not effective and had not identified the issues we found during our inspection, in particular where people and staff were placed at risk of harm or where their health and wellbeing was compromised. Due to the lack of robust quality monitoring there was a lack of consistency in how well the service was managed and led.

The service lacked leadership. People and relatives gave varied opinions about the presence of management within the service. One relative told us, "[Acting manager's name] is always lovely and very caring and I have met [provider's name] once who was also very caring and welcoming." Another person told us, "I may have met the manager but I wouldn't have known it." Although everyone we spoke with felt comfortable approaching the management within the service if they needed to. A care worker told us, "It's nice to work in a friendly environment but we need authority and a leader." Although the acting manager told us they felt supported by the provider there was a lack of managerial oversight of the service as a whole and the provider was unable to demonstrate they assured themselves of the areas of the service that required improvement and were unable to evidence any actions or plans where continued improvements had been implemented to better the service for people.

It was evident that the absence of robust quality monitoring meant that the provider had failed to recognise any risk of harm to people or non-compliance with regulatory requirements sooner. Had there been effective oversight the provider or management team would have acted sooner on serious health and safety concerns we had identified during our inspection, including inappropriate moving of hoists, unsecured fire exits and medication management shortfalls. Furthermore they would have recognised the need for further staff training and support in areas such as person centred care and dignity and respect to people.

Records relating to people using the service and staff employed were not properly maintained. Suitable measures were not in place to ensure that staff were appropriately supervised. Supervisory support arrangements were poor and had not been monitored by the provider to ensure that these were being carried out. Staff had not received an annual appraisal. Medication and safe practice competency assessments had not been formally completed to ensure that staff who supported people within the service were competent to undertake tasks safely and to an appropriate standard.

Care records were not properly maintained or audited, or analysed such as; fluid charts, repositioning charts, care plans, risk assessments and end of life care. The minutes from a managers meeting held in July

2016 highlighted that documents used to record people's care were not being completed adequately as staff were complaining that there was not enough time to fill in the records. These concerns had not been addressed adequately as were still present during inspection, further demonstrating a lack of leadership.

Although weekly air mattress audits had been undertaken; records showed that these were last completed on 13 March 2016. Had this audit been completed each week and been up-to-date, this may have alerted the acting manager and provider sooner to two pressure mattresses being incorrectly set in relation to people's weight. The provider was unable to provide a rationale as to why this lack of monitoring had not been picked up sooner. The acting manager advised that they regularly supported people throughout the day with their personal needs which had taken time away from monitoring the service's quality.

The provider was able to demonstrate to us the arrangements for gaining people's views of the service. This included the use of questionnaires distributed to people who used the service and those acting on their behalf. Relatives told us they had completed these questionnaires. However we were only provided with the outcome of questionnaires for 2015 as 2016 analysis had not been completed. Additionally some of the key highlights identified within the 2015 report had not been actioned to drive improvements. For example; the providers quality assurance report 2015 had identified that people wanted their needs, wishes and preferences to be considered when developing their care plan. However we were told that people and their relatives were not actively involved in regular reviews and developments of care plans other than when a change in need arose.

People and staff were not provided with regular opportunities for the involvement of developing the service. The 2015 provider quality assurance report highlighted that people and relatives wanted more information on when residents meetings were held. We spoke to relatives who repeatedly told us the residents meetings were not held regularly for them to discuss service activity and improvements. We were provided the minutes of the last residents meeting which was held in March 2016. The meeting highlighted a lack of activities, the unreliability of the lift, changes to the environment to aid people with dementia, respect and the need for more residents meetings. These issues were still present during inspection demonstrating a lack of leadership and an ineffective response to people's concerns, recommendations and wishes.

Staff did not consistently report that they felt supported. Minutes of staff meetings were not available as care workers advised us they did not have regular staff meetings to give them an opportunity to express their views and opinions on the day-to-day running and quality of the service. The minutes of a managers meetings held in July 2016 identified that developments were required surrounding; training, staff supervision and appraisals and staff shortages. Although a record had been maintained of the meeting, and concerns identified, it was not possible to determine how these concerns were to be monitored and addressed for the future. The provider advised us during the meeting of the 9 November 2016 that developments had been identified to change the culture of the service and aid staff to take ownership of their role and responsibilities by introducing a mentoring scheme. This would enhance support for staff individually and enable support each other effectively across the service.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment people received was not consistently appropriate to meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not consistently respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Not all staff had an understanding of the legal requirements of the Mental Capacity Act 2005. Policies and procedures for obtaining consent to care and treatment did not reflect current legislation and guidance which staff must follow at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not being provided because the service was not ensuring staff were competent in the management and administration of medicines. Effective auditing systems were not in place to ensure the service was mitigating against risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints raised were not viewed as an opportunity to learn or improve, had not been responded to appropriately and not consistently recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The inadequate monitoring and provision of sufficient numbers of suitably qualified, competent, skilled staff placed people's health and wellbeing at risk.

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 Poor oversight and a lack of leadership resulted in lack of effective governance systems and processes to ensure the provider was mitigating against risks. A warning notice was served with a short time frame to become compliant.

The enforcement action we took:

A warning notice was served with a short time frame to become compliant.