Strathmore Care

Fairview House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Fairview House is a residential care home providing accommodation and personal care for up to 55 people aged 65 and over. This includes people living with dementia. At the time of the inspection there were 35 people living at the service.

People's experience of using this service and what we found
Information relating to people's individual risks were not always recorded or did not provide enough assurance that people were safe. Suitable arrangements were not in place to ensure the proper and safe use of medicines. Effective arrangements were not in place to protect and prevent people who used the service from abuse. The staffing levels and the deployment of staff were not suitable to meet people's care and support needs. People were not protected by the prevention and control of infection. Lessons were not learned, and improvements made when things went wrong.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service.
Rating at last inspection (and update)
The last rating for this service was inadequate (published 14 January 2020) and there were multiple breaches of regulation. This service was placed in 'Special Measures' following our last inspection to the service.

Why we inspected
The inspection was prompted in part due to concerns received about unwitnessed falls and the provider's arrangements for falls management. Other concerns related to unexplained bruising, inadequate staffing levels and inappropriate moving and handling practices. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of 'Safe' and 'Well-Led' only.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed and is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fairview House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Fairview House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by two inspectors on 22 July 2020 and one inspector on 31 July 2020. The inspectors were accompanied by a Specialist Advisor on 22 July 2020, whose specialism related to the management of medicines.

Fairview House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager in post, but they were not yet formally registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to our inspection to the service we formally asked the provider and manager to provide us with a range of information. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We 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 six people who used the service about their experience of the care provided. We collated information relating to 11 people who used the service and this related to specific topics. We looked at the provider's arrangements for managing medication and the prevention and control of infection.

After the inspection
We continued to seek clarification from the provider and manager to validate evidence found. We spoke with seven members of staff between 31 July and 3 August 2020. We spoke with the manager about their role and responsibilities on 7 August 2020. We also provided feedback of our inspection findings to the manager and a representative of the organisation on 7 August 2020. We looked at information relating to people's care and support needs, including risk factors, staff training data, three staff personnel files and the provider's quality assurance arrangements. We spoke with several professionals who have recently visited the service because of emerging concerns.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection to the service in November 2019, effective arrangements were not in place to assess risks relating to the health and safety of people using the service. Improvements were also required relating to the service's medication practices and procedures. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. At this inspection we found not enough improvement had been made and the provider remained in breach of this regulation.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

•Suitable arrangements were not in place to mitigate risks for people using the service and to ensure their safety and welfare. Though safety concerns relating to one person had been identified, actions taken to ensure the person's safety were not robust or addressed quickly enough.

•Where risk assessments were in place, these identified how risks to people's safety and wellbeing were to be reduced and the actions required to keep people safe. However, not all risk assessments to people's wellbeing were completed and up-to-date to support people's safety. This meant information recorded was inaccurate and placed the person at risk of receiving poor and unsafe care. For example, although one person sustained a significant injury in June 2020, their moving and handling risk assessment had not been updated since August 2019. Information noted within the person's care file referred to the person being able to mobilise independently, but this was inaccurate, as the person was no longer able to weight bear.

• Effective arrangements were not in place to ensure medication practices were safe. On the first day of inspection, staff did not refer to the Medication Administration Record [MAR] prior to collecting and administering two people's liquid antibiotic medicine, relying solely on their memory.

• Staff told us one person self-administered one of their medicines but experienced challenges to do this safely because of poor dexterity. Staff confirmed support was provided for this person, including administering of the person's medication on occasions. This was not safe as staff had not received specific training to administer this medicine and relied heavily on the person providing verbal instruction. No information was recorded to demonstrate how the above was safely facilitated and if the person's instruction was appropriate. Following the inspection this was raised as a safeguarding concern with the Local Authority.

•The above person's assessment for the self-administration of this medicine was inadequate as it failed to consider and record the level of support now required to enable the person to self-administer their medication safely. The person's poor dexterity and the responsibilities of staff had not been considered and recorded as part of this assessment.

• On the second day of inspection a member of staff was observed to not sign the MAR charts immediately

after they had administered people's medication. The rationale provided by the member of staff was they had been too busy to complete the MAR charts sooner. This was not in line with national guidance or the provider's own medication policy and procedure.
• On the second day of inspection a thickening powder to aid a person's swallowing difficulties and to minimise the risk of aspiration was not stored correctly to ensure safe storage for a period of 25 minutes. This was easily accessible to others and placed them at potential risk of harm and not in line with the NHS 'Patient Safety Alert: Thickening Powders' dated 2015.
• PRN 'when required' medication protocols were not completed for all medicines administered in this way.
• Where several people were prescribed liquid antibiotics, the advisory label stated the doses should be evenly spread throughout the day. However, records showed the antibiotics were routinely given between 8.30am and 4.30pm each day, compressing three doses together rather than applying them more evenly throughout the day.
•At the last inspection, the provider had failed to learn lessons where concerns had been raised by external agencies supporting the service. At this inspection we found there was a continued failure to learn lessons from incidents that affected the health, safety and welfare of people using the service. There were no formal arrangements in place to ensure safeguarding concerns or incidents were reviewed and monitored to make sure action was taken promptly to remedy the situation and prevent further occurrence. There was no record of actions and lessons learned taken forward from recent events.

Effective arrangements were not in place to mitigate risks for people using the service or ensure medication practices were safe. This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Prior to our inspection concerns were raised by the Local Authority with us about poor moving and handling practices at the service. Though no moving and handling concerns were identified as part of this inspection, not all staff were confident when undertaking this task and were reliant on senior members of staff providing additional support and guidance.

Systems and processes to safeguard people from the risk of abuse
• At our last inspection in November 2019, the provider failed to raise safeguarding concerns with the Local Authority. Prior to this inspection, we found that the management team had not raised safeguarding concerns with the Local Authority or the Care Quality Commission. Effective arrangements were not in place to protect and prevent people who used the service from abuse or potential abuse.
• Following the inspection, the Local Authority confirmed since December 2019 to 6 August 2020, 15 safeguarding concerns had been raised. Of these, three were substantiated, one was partially substantiated, four were not substantiated and seven remained 'open'.
• In March 2020, healthcare professionals were approached by the manager relating to one person's unexplained bruising. However, the severity of the bruising was not reported accurately by the manager and this meant there was a significant delay in getting appropriate healthcare interventions in place and to investigate these concerns internally to safeguard the person. The circumstances leading to the unexplained bruising were not reported to the Local Authority or Care Quality Commission as a safeguarding concern. This was subsequently investigated by the Local Authority with the outcome substantiated.
• A safeguarding concern was raised in June 2020 by an external source. This related to an unexplained injury which resulted in one person being hospitalised. Information provided by the manager showed staff had failed to escalate concerns relating to this person to the management team in a timely manner and to disclose concerns relating to a colleague's alleged poor care practice. This is currently being investigated by the Local Authority under local safeguarding policies and procedures. The Care Quality Commission are reviewing this under their 'Specific Incident' guidance.
• Not all relatives spoken with felt the service was safe. This was because of their concerns about the

service's staffing levels and about their perception of the poor care provided for their family member.
• The above examples demonstrated a lack of understanding by the manager and staff of their individual responsibilities to raise and respond to concerns of alleged abuse at the earliest opportunity. This was despite staff spoken with telling us they would make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the management team without delay. The manager told us there had been a recent incident involving poor moving and handling, but this had not been escalated to the manager.

Suitable arrangements were not in place to protect people from the risk of abuse. This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, the provider failed to ensure staffing levels were adequate to meet people's needs. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements were still required to ensure staffing levels as told to us by the manager were maintained and the deployment of staff was suitable to meet people's needs.

Staffing and recruitment
• Staff told us they did not always have time to sit and talk to people and they found not always having enough staff on duty, stressful. Comments included, "Sometimes staffing levels are short and we struggle, care can be rushed", "If someone calls in sick, there's no effort made to cover" and, "It's just stressful and you're rushed."
•Observations undertaken during both days of inspection showed care provided was task and routine focussed and not person centred. The provider told us during feedback of our inspection findings, they too had identified this as an area for improvement and was looking to provide 'closed culture' training for staff.
• The deployment of staff did not meet people's needs. There were three occasions on the second day of inspection whereby the communal lounge [conservatory] on the ground floor was left without staff support for up to 15 minutes. The only times staff were engaged with people was when staff supported them with their moving and handling needs, when providing refreshments mid-morning or mid-afternoon or supporting people to eat their lunchtime meal.
• Staff rosters provided to us prior to the inspection demonstrated staffing levels as told to us were not always maintained during the day or at night.

We recommend the service review the deployment of staff within the service to ensure it meets people's care and support needs.

Preventing and controlling infection
• The service was clean and odour free. This included both communal areas and people's bedroom.
• Staff confirmed since the onset of the COVID 19 pandemic, they had had access to sufficient supplies of Personal Protective Equipment [PPE].
• Though during both days of inspection staff were observed to wear face masks covering their mouth, these did not always cover their nose. Some members of staff were observed to consistently touch their face and subsequently their mask. Healthcare professionals who visited the service, told us they had also witnessed this. This demonstrated staff's practice was not fully compliant with COVID 19 Personal Protective Equipment [PPE] guidance published and up-dated by Public Health England on 20 July 2020. The impact of this suggested staff were not following national guidance, may not have fully understood their responsibilities and were not protecting people by maintaining good infection control practices.
• On the first day of inspection one member of staff was observed to enter and leave two people's bedroom, checking on both people and handling documents left in the room. Although there was no requirement for

the staff member to wear disposable gloves, neither did they wash their hands or use hand sanitiser.
• A member of staff did not adopt proper and safe hygiene practices when administering one person's medication [drops] into their mouth. The member of staff did not wear any disposable gloves and on completion of this task was observed going to prepare the next person's medication without washing or sanitising their hands. The specialist advisor who was part of the inspection team intervened and spoke to the staff member. This meant poor infection control practices were being followed and there was a potential risk of cross-infection.

We recommend the provider and manager take effective steps to make sure all staff using the service follow national guidance in line with Public Health England and the Department of Health and Social Care to guarantee safe working practices relating to the prevention and control of infection.

At our last inspection the provider had failed to ensure safe recruitment processes and procedures were being followed when employing people to work at the service. This was a breach of Regulation 19 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made and the service was no longer in breach of this regulation.

•Staff had been recruited safely to ensure they were suitable to work with vulnerable people. Though the above was positive, minor improvements were required as only one reference had been sought for one out of three files viewed, and this did not include a reference from their last employer.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in November 2019, effective arrangements were not in place and did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. At this inspection we found not enough improvement had been made and the provider remained in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

• Governance arrangements were not reliable or effective to make the required improvements. The lack of effective oversight and governance of the service has resulted in continued breaches of regulatory requirements relating to medicines management and governance. An additional regulatory breach has been cited relating to safeguarding.
• Though medication audits were completed at regular intervals to assess and monitor the quality and safety of the service, these failed to pick up issues highlighted during this inspection. Where areas for improvement were detailed, there was no action plan recorded detailing how these were to be or had been addressed by the management team to ensure future learning.
• Concerns were raised by the Local Authority relating to the incidence of falls and the management of these at the service. We requested a copy of the service's falls analysis and found this provided limited information. No information was recorded detailing the actions being taken to mitigate the risk and the control measures in place to ensure the risk was as low as possible going forward.
• The overall management of the service did not ensure it was consistently well-managed and led. Findings at this inspection demonstrated the provider and management team of the service were not continuously learning to improve people's care and to keep them safe. As stated within the domain of 'Safe', there was evidence to demonstrate a failure from the management team to ensure people using the service were safeguarded against the risk of harm and abuse.

• A culture of openness and transparency was not followed by the management team as incident reports and subsequent internal investigations were not routinely initiated or completed to ensure learning and lessons learnt.
• The provider's own policies and procedures were not always followed by the management team. For example, where people using the service had experienced an accident or where there had been an incident and the person suffered an injury, a full and accurate record of events had not been documented and subsequent 'accident and incident' forms were not completed.
• The management team did not understand their responsibility to ensure notifications relating to specific incidents, such as, significant injuries to a person, any abuse or allegation of abuse, had been made to the Care Quality Commission.
• Findings at this inspection demonstrated the management team did not lead by example. Effective role models, for example senior members of staff, were not able to provide valuable support and guidance to staff to enable them to effectively carry out their roles. There was a lack of oversight by the management team and senior members of staff to identify and pick up poor practice, such as, staff not wearing their PPE correctly, staff not effectively communicating with people in a respectful and meaningful way when providing care and support and poor medication practices.
• At our previous inspection to the service the provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each person. At this inspection improvements were still required to ensure recording was accurate and up-to-date. The manager told us people's care plans were checked and audited by senior members of staff each month and by the management team every three months.
• Not all members of staff felt the manager was supportive, particularly when the service was short staffed.
• The manager told us they were supported by the provider. However, the manager confirmed they had not received formal supervision since commencing in post in December 2019 and despite the service being rated 'Inadequate' and placed in 'Special Measures' following our last inspection.

Arrangements were not in place to make sure effective systems and processes were in place to assess and monitor the service to ensure compliance. This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• We did not look at the provider's formal arrangements for engaging and involving people, the public and staff on this focussed inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment Effective arrangements were not in place to mitigate risks for people using the service or to ensure medication practices were safe.

The enforcement action we took:

We removed the location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Suitable arrangements were not in place to protect people from the risk of abuse and to keep them safe from harm.

The enforcement action we took:

We removed the location from the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to mitigate risks for people using the service or to ensure medication practices were safe.

The enforcement action we took:

We removed the location from the provider's registration.