Fairview Care Home Ltd

Fairview House

Inspection report

37 Clatterford Road
Newport
Isle of Wight
PO30 1PA

Tel: 01983718681
Website: www.fairviewcarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This inspection took place on 15 & 17 November 2016 and was unannounced. The home provides accommodation and personal care for up to 24 people, including people living with dementia. There were 20 people living at the home when we visited.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our previous inspection in December 2015, we identified a breach of regulation as the provider had not displayed their CQC performance rating as required. At this inspection we found action had been taken; the rating was displayed prominently on the premises and on the provider's website.

People's safety was compromised in some areas. The risks of people falling were not managed effectively. There was no clear policy or procedure in place to protect people with a history of falls; advice from specialists was not always followed and use was not made of equipment that could monitor people's movements. The registered manager did not analyse the incidence of falls, so could not take remedial action to reduce them.

People told us there were not always enough staff deployed to meet their needs. On the morning of the first day of our inspection, there were not enough care staff and people did not receive the necessary support with their care needs. When additional staff arrived later in the morning, the atmosphere calmed and people were attended to promptly. Staff told us, and the duty rotas confirmed that the staff shortages had been common in recent weeks.

A cleaner was supporting the care staff, but this had had a knock-on effect with their work. We found some people's bedrooms smelt of urine as the floors had not been mopped; one person's sheets were badly stained and another person's mattress was spattered with a brown substance. Instead of being changed, the mattresses had been turned over and made ready for the person to sleep on.

Staff knew how to prevent, identify and report abuse. However, money kept on behalf of people was not stored securely and put people at risk of financial abuse. We discussed this with the registered manager who took immediate action to store it securely.

There was a clear management structure in place, but responsibilities had not been delegated to senior staff. This put a heavy burden on the shoulders of the registered manager who did not have the time to take an overview of the service or identify and implement the necessary improvements.

The registered manager was not supported to access advice or guidance from their peers, so were not up to

date with current practice, such as the requirements around the duty of candour regulations. Consequently, they had not provided written information to the relative of a person who had sustained a serious injury during a fall. Links had not been developed with community groups and people were not supported to leave the home and access the community.

Regular checks were conducted to make sure the building was safe for people and there were arrangement in place to deal with foreseeable emergencies. There were appropriate arrangements for managing medicines. Pre-employment checks were conducted to help ensure staff were suitable to work at the home.

Sttaff were skilled and suitably trained. New staff completed a comprehensive induction programme and all staff were suitably supported in their roles by the managers.

Staff followed legislation to protect people's rights and freedoms. They sought consent from people before providing care or support.

People praised the quality of the food. Their dietary needs were met and staff provided people with appropriate support at lunchtime to help ensure they ate and drank enough. Staff monitored people's weight and took action if they started to lose unplanned weight. People could access healthcare services and were referred to doctors and specialist nurses when needed.

People were usually cared for with kindness and compassion. Staff interacted with them in a positive way. They spoke about people warmly and demonstrated a detailed knowledge of them as individuals. They were skilled at communicating with people living with dementia.

Staff protected people's privacy and involved people in the care planning process. They kept family members up to date with any changes to their relative's needs.

Arrangements were in place to help ensure people experienced a comfortable, dignified and pain-free death. Staff had received training in end of life care and, following feedback from relatives, had signed-up to refresh this training by completing an extended course at a local college.

People received personalised care and support that met their needs. Care plans had been developed which provided staff with information about how to meet people needs. People were encouraged to make choices about every aspect of their daily lives and had access to a range of activities within the home.

The provider sought and acted on feedback from people. There was an appropriate complaints procedure in place and people knew how to make a complaint.

A quality assurance process had been developed. This had identified and addressed some areas that needed improvement. The provider promoted the value of dignity, which staff worked to.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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?

Inadequate

The service was not safe.

People experienced frequent falls and were not protected effectively from the risk of falls. Falls management procedures were not robust and appropriate action was not always taken to reduce the level of risk.

There were not enough care staff to support people effectively at all times. Cleaning staff and management had to support care staff, which had a knock-on effect on the cleanliness of the home.

Some bedrooms, bedding and a mattress were not clean and repair work was needed in the laundry to make the environment hygienic.

Most people felt safe at the home and staff knew how to identify, prevent and report abuse. However, people's money was not kept securely, which put them at risk of financial abuse.

Other environmental and individual risks to people were managed effectively. There were suitable plans in place to deal with foreseeable emergencies. The process used to recruit staff was safe.

Is the service effective?

Good

The service was effective.

Staff were suitably trained to enable them to provide effective care to people. Staff were supported appropriately in their role and could gain vocational qualifications.

Staff followed legislation designed to protect people's rights and freedoms.

People's dietary needs were met and, with the exception of breakfast on the first day of the inspection, received appropriate support to eat and drink.

Improvements had been made to the environment to support

the needs of people living with dementia. People were supported to access healthcare services including doctors and specialist nurses.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They protected people's privacy and dignity at all times.

Arrangements were in place to help ensure that people experienced a comfortable, dignified and pain-free death.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People had access to a range of activities and were encouraged to make choices about every aspect of their lives.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a clear management structure in place, but responsibilities had not been delegated which put undue pressure on the registered manager. The registered manager was not supported to access current best practice advice to help deliver a safe, effective and open service.

Visitors were made welcome, but links had not been developed with the community to help keep people in touch with events outside of the home.

Staff were positive about the management and felt supported in their role, although some reported low morale caused by the pressure of work.

There was an appropriate quality assurance process in place which had led to improvements in the service.

The values of homeliness and dignity, which the registered manager promoted, were understood and followed by staff.	

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.

This inspection took place on 15 & 17 November 2016 and was unannounced. It was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home and seven family members. We also spoke with the registered manager, the deputy manager, five care staff, three housekeepers and the cook. We looked at care plans and associated records for seven people, staff duty records, recruitment files, records of complaints, accident and incident records, and quality assurance records. We also view the care records of a person who had died, so we could assess the end of life care they had received.

We observed care and support being delivered in communal areas of the home. 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.

Inadequate

Is the service safe?

Our findings

People were not protected from harm as the risk of people falling was not always managed effectively. Four people or their family members told us people had experienced a high level of falls at the home. A family member told us that they felt measures taken to protect their relative were not adequate. They said, "I put [my relative] in here to be safe; and at night she wasn't. I felt something more could have been done to keep her safe." Another family member said, "When I visited on Sunday I found out [my relative] had fallen out of bed the night before. I wasn't impressed; that was only his second day here. He has hurt his back."

When we looked at the accident records we found one person had had seven falls in a four month period; another had had 15 falls in a five month period; and another had had 19 falls in a seven month period. A further person had had three falls since being admitted to the home five days before our inspection. Most falls had resulted in minor bruising or skin tears, but one had resulted in a fracture to the person's eye socket.

One person had been referred to the falls clinic for advice in the middle of May 2016. However, the specialist advice was not followed. Staff at the falls clinic had recommended the provider changed the colour of a handrail the person used for support to make it more visible to them and this had not been done. They also recommended the use of a 'mattress sensor' to alert staff when the person got out of bed, but this was not done either. At the end of May 2016, a physiotherapist had provided details of leg strengthening exercises for the person to do, but the registered manager was unable to confirm whether the person had been supported, reminded or encouraged to do these. The person had fallen 10 times since that time.

Some measures had been taken to keep people safe following falls. For example, the layout of people's rooms was changed to make the environment less hazardous; people were offered a ground floor room where they could be monitored more easily; people had been referred to their GP for their medicines to be reviewed. However, the provider did not have a clear policy in respect of falls management to advise staff when risk assessments should be reviewed and what actions should be considered to manage the risk. People's care records showed that the risk of them falling had been reviewed at varying times, but there was no clear audit trail to confirm whether additional measures had been put in place or whether these had been successful.

The provider did not analyse the frequency of falls across the home in order to identify any patterns. They could not tell us how many falls there had been in the past month, or the time and place when they were most likely to occur. Therefore, they were unable to take remedial action such as deploying extra staff at key times or places to provide additional support to people.

The registered manager told us they did not use pressure-activated mats to alert staff when people at risk of falls had got out of bed or moved to unsafe positions; they said people were inclined to step over them and they presented a trip hazard. Instead, they used a 'listening device' which enabled staff to monitor the sounds in the person's room. The frequency of falls within the home indicated that this was not always an effective measure. A director of the provider's company told us they would review the use of monitoring

equipment at the home and re-introduce pressure-activated mats, or similar devices, if appropriate.

The failure to assess and mitigate risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff deployed to ensure people's needs were met in an effective way. One person told us, "I am left waiting to go to the toilet, it's awful, I nearly go in my pants." On the first morning of the inspection a person was sat at a dining table and wished to be supported to move to the lounge. They said, "I have to wait a long time before being moved to a [lounge] chair, I've been sitting here for ages." Another person said, "[Staff] leave people too long before helping them to the toilet." This was echoed by family members. One told us, "The staff are very caring, but sometimes they are very stretched and it takes time to get things done like changing [people's continence pads]." Another said, "There is not enough staff for the residents."

The registered manager told us five care staff were needed for the morning shift. On the first morning of the inspection there were only two care staff available, plus the registered manager and the deputy manager, to support people. One of the cleaners was helping people with their breakfasts, which they said they had had to do a lot in recent weeks. The atmosphere in the home was chaotic and disorganised. The registered manager and the deputy manager were undertaking medicine rounds at the same time, using two medicines trolleys, but were called away to support people on a number of occasions. This increased the likelihood of making mistakes with the administration of medicines. At one point, one of the managers dropped some of tablets on the floor that had to be discarded.

The cleaner who was supporting someone to eat their breakfast was also repeatedly called away to support other people. Some people were sat in lounge chairs or at dining tables asleep, with their breakfasts in front of them. There were not enough staff to support and encourage them to eat. The two care staff members were getting people up. They appeared stressed and overwhelmed with work. One of them became frustrated when they were unable to get a wheelchair through a doorway and moved a person sat on a dining chair without any discussion or warning. Shortly afterwards they started clearing breakfasts away that had not been eaten and taking clothes protectors off people without checking whether they had finished eating. Another staff member told them to put one person's food back as the person hadn't finished it. When additional staff arrived later in the day the staff member visibly relaxed and was observed providing support in a positive, kind and caring way.

Staff told us the shortages meant they were task focused and were not able to spend time talking with people. They said the workload was "heavy" as 10 of the 20 people living at the home needed the support of two staff members to transfer from chair to chair or to use the bathroom. A staff member told us, "It's been quite hectic. We had three new [people] at once and it's been difficult to get to know them. We're asked to do extra hours, but it stresses [staff] out. We've got a lot of vocal residents and it causes a domino effect; when one starts [calling out], they all follow." Another staff member said, "I don't feel there are enough staff; there's normally only been four [care staff] on over the past few months and we need five." A third staff member told us, "[People] get the care they need, but we may not have time to talk and chat. [One person] likes to try and walk but [needs a lot of support] and we just don't have the time."

During the morning of the first day of the inspection, a staff member came in on their day off and two staff members from the provider's neighbouring home arrived to help. This provided an appropriate level of staffing; the atmosphere calmed, people became more settled and staff had sufficient time to attend to everyone that needed support. On the second day of the inspection (which was announced), there were also sufficient staff.

We looked at staff duty rosters for the week of our inspection and for the previous two weeks. We found the specified staffing levels had been achieved on just less than half of these days. The registered manager told us the provider did not allow them to use agency staff to cover staff absence, and they did not usually use staff from the provider's other home to assist. They said they were normally only able to cover absence by using existing staff who were prepared to work additional hours, which some were reluctant to do because of the pressure. They had vacancies for: a head of care, a senior care staff member to work night shifts and two care staff to work day shifts.

The failure to ensure sufficient staff were deployed to meet people's needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Non-care staff also told us their workloads were too high. One told us they "need more hours to do the job properly". Another said, "It's really hard to get the work done in the time available" and a third told us, "There's too much work; sometimes I go home in tears. I've spoken to the owner about it, but nothing happens." The cleaners told us the requirement to support care staff at breakfast time meant they had less time for daily cleaning and this was evident when we checked people's bedrooms. For example, some rooms smelt of urine as the floors had not been mopped that day. Care staff were responsible for making people's beds and these were not always clean. The bedding of one person's bed was dirty and heavily stained and the mattress of another person's bed was spattered with what appeared to be faeces. The mattress had been turned over so the spatters were not immediately evident and the bed re-made ready for the person to use.

The laundry room had a sink built in to a base unit. The unit was broken and coming away from the wall. The walls were decorated with woodchip paper that was peeling off. It was not a suitable or clean environment in which to launder people's clothes.

We brought these issues to the attention of the deputy manager who told us they were not acceptable. On the second day of the inspection we found the bedding and mattress had been changed and a new sink unit was being installed in the laundry room.

The failure to ensure premises and equipment were clean and properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service looked after small amounts of money on behalf of people. This was kept in a money tin in a cupboard in a busy room used by staff and visitors. The cupboard was not locked, which put people's money at risk. When we addressed this with the registered manager they took action to store it in a more secure place.

In other respects, staff protected people from the risk of abuse. One person told us, "I am very happy here and I feel safe and well cared." Staff had the training, knowledge and confidence to identify, prevent and report safeguarding concerns, and acted on these to keep people safe. For example, staff were aware of people who were at high risk of abuse because of the way they interacted with others. We saw staff acted quickly to defuse situations when interactions between people became heated. Staff told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. They were also aware of external organisations they could contact for support, including the local safeguarding authority and CQC. Where safeguarding concerns were identified, the registered manager conducted thorough investigations and took appropriate action to keep people safe.

Staff demonstrated an understanding of how to reduce the risk of people developing pressure injuries and

used a nationally recognised tool to assess individual risks to people. No one was experiencing pressure injuries at the time of our inspection. Repositioning charts and preventive equipment, such as pressure relieving cushions and special mattresses were in use. One mattress was not adjusted to the right setting, which the deputy manager attended to, but all others were set correctly. A process was used to check mattress settings on a weekly basis. One person needed to be supported to reposition every two hours to prevent pressure injuries and records confirmed staff did this.

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines. One person told us, "I always get my medication when I need it." Staff were suitably trained to administer medicines and had their competence assessed every six months by the registered manager. Medication administration records (MAR) confirmed that people received their medicines as prescribed. Comprehensive information was available to guide staff when administering 'as required' medicines, such as pain relief and sedatives, to help ensure they were given in a consistent way and suitably spaced. Another person told us, "I get paracetamol when I need it, every four hours." There was also an effective process in place to help ensure topical creams were not used beyond their 'use by' date. The registered manager undertook weekly stock checks of medicines to help ensure they were always available to people.

Risks posed by the environment had been assessed and were being managed appropriately. Equipment, such as hoists and lifts were serviced and checked regularly. Upstairs windows had restrictors in place to prevent falls and fire exit doors were alarmed so staff would be aware if anyone had left the building without staff support. The temperature of hot water at water outlets was controlled through special valves and maintenance staff monitored these regularly. This helped protect people from the risk of scalding.

There were plans in place to deal with foreseeable emergencies. The provider had a sister home in a neighbouring town, and arrangements had been made to share resources in the event of an emergency. An emergency bag had been prepared containing contact details for staff, management and contractors available out of hours, together with personal evacuation plans for people. These included details of the support they would need if they had to be evacuated. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly.

Robust recruitment processes were followed and staff were checked for their suitability before being employed by the service. Staff records included an application form, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

Good

Is the service effective?

Our findings

Staff were skilled and suitably trained to enable them to provide effective care to people. One person said of the staff, "They do what I want them to do." A family member told us, "The care here is okay; I'm happy with that." Another told us, "Staff know what they are doing."

We observed people were wearing clean clothing that was appropriate for the weather and that their individual personal grooming needs were met, such as haircare and nail care. One person needed support to reposition every two hours and the person's relative confirmed this was always provided.

Records showed staff training was mostly up to date. Where refresher training was needed, we saw dates had already been set for this to be delivered. Most staff had been supported to gain relevant vocational qualifications and one staff member was undertaking specific training to prepare them for a senior care role at the home.

New staff completed a comprehensive induction programme together with 'shadow shifts', where they worked alongside experienced staff, before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake training that met the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Staff demonstrated an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques; and they explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance. Some people were not able to verbalise their preferences, so at lunchtime staff offered them choice by showing them two plates of food and allowing them to indicate which one they preferred. This showed an understanding of people's individual communication styles.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision, which were recorded. These provided an opportunity for one of the managers to meet with staff, discuss their training needs, identify any concerns, and offer support. One staff member told us, "I feel supported and appreciated. The managers try to spend more time with us now." Another staff member said, "The supervisions are okay; we discuss training, workload, management, people's needs. If we need anything we can just ask; the managers are approachable."

The deputy manager told us they also provided supervision and support by working alongside staff on a day to day basis and dealing with any issues as they arose. A new, more structured, format for staff supervisions was being rolled out. It included observations of staff practice and assessed key aspects of their roles, including communication skills, moving and handling, privacy, dignity and consent. Once established, this would support staff to further enhance their skills in these areas.

Yearly appraisals of staff were conducted by one of the directors of the provider's company. Some staff

questioned whether this was effective as the director did not work closely with them. The registered manager told us they contributed to the appraisal process for each staff member but were not always informed about the outcome and did not see the written appraisal afterwards. This meant they were not aware of any development needs or performance issues that had been raised with the director. We discussed this with the director who undertook to share the outcome of appraisals with the registered manager in future.

People praised the quality and choice of food and said they enjoyed all the meals. One person said, "Lunch was very good, I love the rice pudding." Another person told us, "I love all the food." People were given a choice of meals and drinks. If they did not want the menu of the day, they were offered alternatives. For example, one person did not eat their salad and requested porridge, which they were given. Another person asked for a sandwich, which they received.

With the exception of breakfast on the first day of our inspection, people received appropriate support to eat and drink at all other times. Staff were attentive to people at lunchtime, offering them encouragement to eat when needed. People who needed full support to eat received this on a one-to-one basis in a dignified way. One person started using their knife to eat and were offered a spoon instead, which proved more effective. Care staff and kitchen staff were aware of people's dietary needs and preferences, which were clearly recorded in their care plans. One person told us they were given smaller portions of dessert as they were diabetic. They said, "[Staff] only let me have one slice of carrot cake although I could choose to have more." Drinks were available and within people's reach at all times. A variety of cups, beakers and straws was made available to suit people's individual needs and helped people to remain as independent as possible.

Staff monitored people's weight on a monthly basis. If unplanned weight loss was identified, they took appropriate action. This included closer monitoring of the person's intake, through the use of food and fluid charts, referring the person to their GP for advice and providing food supplements.

Staff protected people's rights by following the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We heard staff seeking people's consent before providing care or support and they were skilled at understanding people's wishes. For example, while some people were able to give consent verbally, others could only express themselves through their body language which staff were able to interpret.

Care records confirmed that where people lacked capacity to make decisions, staff completed assessments using the recommended two-stage test. They consulted with family members and made decisions in the best interests of people. These included decisions relating to the administration of people's medicines and the delivery of personal care.

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. We found the provider was following the necessary requirements. DoLS authorisation had been approved for three people and applications had been made for most other people in accordance with the latest guidance. Staff understood their responsibilities and knew how to keep people safe. For example, a staff member told us, "Most people would not be safe to leave on their own, so if they try we have to calm

them down and defuse the situation. It usually means they want to do something, so we suggest [activities]. With one person, it helps if we let them speak with their care manager on the telephone."

Some improvements to the environment had been made since our last inspection to support people living with dementia. One person's door had been decorated to make it look like the front door of a house and staff told us this had helped the person recognise their room. Large signs helped people navigate around the home and identify where the bathrooms were. A family member told us, "[My relative] can now find their own way to the bathroom which helps her independence." A wall in the dining room called the 'hall of fame' had been decorated with photographs of well-known people, such as actors, sports personalities and musicians. The registered manager told us people had chosen the pictures themselves and staff used them to prompt conversations and help people reminisce about the past. For example, one person enjoyed boxing and had asked for a photograph of a famous boxer to be included, who they liked to talk about.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, nurses and chiropodists. They also had access to dental care and eyesight tests when needed. If a person was admitted to hospital, a staff member usually accompanied them to aid communication between them and medical staff. If they were unable to do this, pre-prepared information was sent with the person, detailing their medical history and care needs.

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. One person said, "Everyone's pretty good here really." A family member told us, "Staff are kind and speak nicely to [my relative]."

With the exception of the first hour of our visit, when staff were under pressure due to the shortages, all other interactions we observed between people and staff were positive. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. When people were supported to move, using hoists or other equipment, staff worked in pairs, explained what they were doing, took their time and reassured the person throughout. One person was asleep at lunchtime and was woken calmly and gently. They took a long time to come round, so their meal was taken away and kept warm until they were more alert and ready to eat it.

Staff spoke about people warmly and demonstrated a detailed knowledge of them as individuals. For example, we heard a staff member ask a person; "How did you sleep last night?" When the person said "Alright", the staff member commented, "That's good, because you haven't been sleeping well lately".

When people, for example those living with dementia, struggled to express themselves, staff observed the person's body language and facial expressions and were able to understand their needs from their knowledge of the person. They spent time engaging with people at eye level, used supportive communication techniques and touch appropriately. For example, when a person became upset and started crying, a staff member put their arm around them and gave reassurance. When a person became confused and starting asking for their family, staff reminded them that their relative had visited earlier and would be back again later.

People's privacy and dignity were protected. One person, who stayed in their room, preferred to leave their door open, but this had resulted in other people entering their room uninvited. To prevent this, staff had installed a retractable belt to pull across the doorway. This had provided a visible barrier and had been effective in deterring unwanted visitors. Staff made sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and preventing interruptions by making sure other staff knew where they were. Staff knocked and sought permission before entering people's rooms. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plan review records showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives.

We looked at the arrangements for ensuring people received the care they required to have a dignified and

pain free at the end of their life. We found all but two staff had received training in supporting people and their families at the end of their lives. Following feedback from two relatives, the provider had arranged for this training to be refreshed and all care staff had signed up to complete an extended course in end of life care at a local college.

We reviewed the care plan of a person who had received end of life care at the home and found all essential elements had been put in place to help ensure they experienced a comfortable, dignified and pain-free death. A 'last wishes' document had been completed with the person's family. A decision not to attempt cardiopulmonary resuscitation had been discussed and put in place. There had been regular visits by the person's GP, with the outcomes properly recorded. The family had been kept up to date with any changes in the person's condition. Hourly checks had been conducted to assess the need for pain relief. The person had been supported to change position at appropriate intervals and they had been given regular mouth care.

When we spoke with staff, they demonstrated an understanding of the importance of providing effective end of life care; comments included: "You only get one chance to get it right"; "It's as much about supporting the family as the person"; and "[People receiving end of life care] need regular checks as things can change very quickly". The registered manager described the process they followed after a person's death, in order to preserve their dignity. This included all staff standing by the door when the person was taken away by the funeral directors in order to "say good-bye" to them. They said this also helped staff come to terms with the loss, especially when they had cared for the person for a long time and had grown close to them.

Good

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support; which people needed to be encouraged to eat and drink; the support each person needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility varied from day to day and were able to assess and accommodate the level of support they needed at a particular time.

People had access to a range of activities throughout the week which were advertised on the home's notice board. One family member told us, "They have entertainment. People get their nails done and there are two or three singers who come and get people singing along; [my relative] always enjoyed that." Another family member said the activities were "fine for [my relative] and meets her needs". On the first day of the inspection, we observed an external activity provider interacting with people to provide some gentle physical exercise. Later, a person brought dolls in for people to interact with, which proved popular. On the second day of the inspection, two musicians attended to entertain people. Judging from people's reactions, this was a popular event; people joined in with the singing, tapping their feet and clapping along with the tunes. At other times, age appropriate music was played in the lounges which people seemed to enjoy and occasionally sang along with.

People were supported and encouraged to make choices about all aspects of their lives, including when they got up and went to bed, where they took their meals, where they spent their day and how often they bathed. One person said, "It can be very noisy in the lounge, but I can go off to my room if I want to." Staff told us people could choose a bath or a shower; while most preferred theirs in the morning, two people often asked for a shower in the afternoons and this was accommodated wherever possible. One person was reluctant to receive personal care; they declined a bath but accepted the offer of a shave. A staff member told us, "Some people don't verbalise their choices, but their eyes will go to something; like when getting dressed, you offer them two [items of clothing] and they may look at one of them; that's how they choose." When a person was being taken through to lunch, the staff member invited them to choose where to sit and offered a choice of "Feet up or down [on the wheelchair footplates]" once settled at the table.

Staff understood people's needs and how to meet them. One person repeatedly tried to stand up, which staff told us usually indicated that they needed to visit the bathroom, were hungry or were in pain. We heard them explore these options; they supported the person to visit the bathroom, gave them a meal and the person then settled. When another person became anxious at lunchtime, the staff member supporting them to eat closed the lounge doors to reduce distractions and give the person some privacy.

People's care plans were informative and provided guidance to staff about how they should meet people's needs. They included sections on: medicines; continence; skin integrity; nutrition; personal care and mobility. The care plans were centred on the needs of each person and detailed their normal daily routine, their backgrounds, hobbies, interests and personal preferences. For example, they specified whether people preferred baths or showers and how often they liked to receive them. They also indicated when people

preferred to get up and go to bed. Records of daily care provided confirmed that people received care in a personalised way in accordance with their individual needs. Reviews of care were conducted each month. Any identified changes were updated in the person's care plan, and communicated to other staff, to help ensure people's changing needs were known and met. Records showed that people and their relatives were consulted as part of this process.

The provider sought feedback from people and their families in a variety of ways. These included the use of questionnaire surveys and 'residents meetings' which were well-attended by people and their families. In addition, staff were encouraged to take feedback from people and their families at every opportunity and reported this back to the registered manager. One person had asked for a clock in the dining room and we saw this had been provided. A family member had asked for menus to be displayed and this had been done. Other family members had asked for people to have access to fresh fruit and we saw bowls of fruit available in communal areas of the home. Following concerns about clothing going missing in the laundry, a staff member was recruited to operate the laundry full time. They checked people's clothes were correctly labelled and had reduced the frequency of clothing going missing.

People knew how to complain about the service and the complaints procedure was prominently displayed. People and family members felt staff were approachable and that any concerns or complaints would be listened to and addressed effectively. One complaint had been received in the past year and we saw it had been dealt with appropriately in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, in December 2015, the provider had failed to display the CQC performance rating on the premises or on their website. At this inspection we found the provider had taken action. The performance rating was clearly displayed in the entrance hall of the home and on the provider's website, including a link to allow people to view our inspection report.

All but one person were satisfied with the management of the home. One person told us the managers were "lovely" and said they "do a good job". A family member echoed this and said they were "full of praise" for the management of the home. There was a clear management structure in place. This comprised of the two directors of the provider's company, the registered manager, the deputy manager and senior care staff. However, the majority of responsibilities rested with the registered manager who told us they were working excessive hours to cope with the workload. They said they had not had time to delegate areas of responsibility to the deputy manager as the deputy manager had to "cover the floor" most of the time. In addition, they had been unable to recruit a 'head of care' to take responsibility for care planning. At the time of inspection, the registered manager's responsibilities included: quality assurance, staff duty planning, staff wages, ordering and managing medicines, taking the lead on infection control and reviewing people's care plans. This meant they did not have the time needed to take an overview of the service, identify improvements and implement them in a timely way. For example, the deputy manager told us, "We want to put 'champions' in place, like a dignity champion and a dementia champion, but it's finding the time to do it."

The registered manager told us they felt "under pressure to fill the rooms" when they became available. They said this had recently led them to accept three new admissions, within two days, during a period when they were short staffed. They added, "[The director] doesn't understand the reality of what he's asking." Staff told us the decision to take three admissions in two days was "not ideal" although they felt the new people had settled in fairly quickly. One staff member said, "Three new people made it a busy week and where we were short staff it was a stressful week."

Although the directors operated another service in a neighbouring town, they did not have arrangements in place to support the registered manager by sharing policies, procedures and best practice between the two services. When we spoke with one of the directors, they were surprised to learn that movement detection devices were not being used at Fairview House to monitor the movement of people at risk of falling. Whilst acknowledging that they were not suitable for every situation, they said these were routinely used to good effect in their other service.

The registered manager attended the same training events as their care staff, but did not belong to the local care home association or the managers' network, so was not able to seek advice or guidance from their peers. This meant they were not alerted to developments in the provision of adult social care or changes to best practice guidance. For example, the registered manager had developed their own Duty of Candour policy to help ensure staff acted in an open way when people came to harm. However, they were not aware of the need for family members to be given information in writing when their relatives suffered a serious

injury. The policy did not include this requirement and when a person sustained a serious injury during a fall, their relative told us they had not been given the necessary information in writing. When we brought this to the attention of the registered manager, they took action to amend the policy and ensure that written information was given in the future.

Visitors were welcome to visit and any time and told us they were always offered drinks. However, the service had not developed any links with community groups, faith groups or charitable organisations and no activities were organised outside of the home. Therefore, the only opportunity people had to access the community and interact with the wider world was if they had family members who could take them out. The experiences of people without relatives who took an active interest in them was limited to day to day events and activities within the home. We discussed this with the registered manager, who acknowledged the potential benefits to people of building links with the community but said, "Taking people out is not achievable; we just don't have the time."

While staff told us they enjoyed working with people at the home, some reported low morale due to the shortages of staff and the resulting pressure of work. A staff member said, "I love working here, but morale is poor. The manager is trying her real hardest, but is up against it." Staff said they felt supported and valued by the registered manager and the deputy manager. One staff member told us, "They always thank me. Like today, I was thanked for staying on [when they were short of staff]." Another staff member said, "There used to be a high turnover [of staff], but it's better now and we've got a good group [of staff] and help each other out."

One of the directors visited the service weekly, but did not use the visits to undertake any structured assessments or monitoring of its performance in relation to the essential standards of safety and quality. These were done by the registered manager who completed a range of audits, including: infection control, the management of medicines and care planning. Following the audits, improvement actions were identified and implemented. For example, the medicines audit had identified that the medicines fridge was not working correctly, so a new one had been ordered which arrived during the inspection. The infection control audit had led to the purchase of more pillow protectors and to staff being reminded of the home's policy in respect of wearing false nails.

An audit of people's bedrooms was conducted two to three times a week by the deputy manager. Although this had not identified the cleanliness issues we found on the first day of the inspection, records showed that the process had been effective in identifying cleanliness concerns on other days. For example, following previous checks, staff had been asked to clean commodes or re-make people's beds.

To help address the shortage of staff, the registered manager was actively recruiting new staff. They were also taking action to help reduce the level of staff absence caused by sickness. They monitored staff sickness using a spreadsheet that allowed them to identify the frequency of staff sickness and any patterns. As a result, they had been able to take appropriate action in accordance with the provider's attendance management procedures. These included the holding of meetings with individual staff members to discuss their attendance record and these had led to reduced levels of sickness for some staff members. The registered manager was considering further developments to their attendance management procedures using a nationally recognised tool.

The registered manager told us the vision and values of the home were to provide a homely, dementia-friendly environment and to promote people's dignity. They said they did this by reinforcing the vision at staff meeting and during staff supervisions. On the wall of the laundry we saw speech bubbles containing messages to remind staff to treat people's clothing with care and respect. Staff, people and family members

had also written short messages about the importance of dignity on leaf-shaped pieces of paper that were to be added to a 'dignity tree' in the home. From observing the way staff worked, it was clear that they understood the vision and worked to achieve it on a daily basis.

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 provider had failed to assess and mitigate risks to the health and safety of people using the service effectively. Regulation 12(1) & 12(2)(a) & (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the premises and equipment used by people were clean and properly maintained. Regulation 15(1)(a) & (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of suitably qualified, competent and skilled staff were deployed in order to meet their needs. Regulation 18(1).