Oakray Care (Fairhaven) Limited

Fairhaven Care Home

Inspection report

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31 January 2019
05 February 2019

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22 February 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Fairhaven is a residential care home that was providing personal care to 21 people aged 65 and over at the time of the inspection. People living at the home had a range of care needs, including people living with dementia.

People's experience of using this service:
• At the last inspection in December 2017 we found risks to people were not always effectively managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and provider was required to make an action plan for improvement. At this inspection we found improvements had been made and there were effective systems in place to respond to incidents, which included reporting to the local authority where appropriate.

• At the last inspection we also identified concerns around the homes governance, and found systems did not ensure the quality and safety of the service was assessed, monitored and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we told the provider to take action. During this inspection we found quality assurance was effective, and the registered manager completed regular audits to identify concerns and drive improvements in the quality of care delivered.

• Risks to people and the environment were effectively managed though robust assessments and people were appropriately protected from the risk of abuse and avoidable harm.

• People and relatives told us they were happy with the care and support provided at Fairhaven.

• People were supported to receive personalised care to meet their needs and care records were person-centred to reflect people's likes, dislikes and preferences.

• People and relatives were involved in the planning and delivery of their care, and the registered manager sought regular feedback from people.

• People were supported to receive their medicines safely and in a timely manner by staff who were appropriately trained for their roles.

• People's rights and freedoms were upheld and staff treated people with dignity and respect.

• People were encouraged to make their own choices and decisions as appropriate, and where people required additional support with this staff followed best practice guidance and legislation to support them.

• People had access to a range of activities to meet their interests, which were flexible to meet their

individual needs.

• The service met the characteristics of Good across all areas. More information can be found to evidence this in the full report.

Rating at last inspection:
This service was previously rated as Requires Improvement at the last comprehensive inspection. This report was published on 22 February 2018.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

Follow Up:
There is no required follow up to this inspection. However, we will continue to monitor the service and will inspect the service again based on the information we receive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	Good
Is the service effective? The service was effective Details are in our Effective findings below.	Good
Is the service caring? The service was caring Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	Good

Fairhaven Care Home

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

Inspection team:
This inspection was carried out by one inspector, one inspection manager and an expert by experience with an area of expertise in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Fairhaven is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 21 people, including people living with dementia in one adapted building. There were two double bedrooms and 17 single bedrooms. Bedrooms and bathrooms were laid out across two floors with access to a stair lift.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The manager had not changed since the last inspection.

Notice of inspection:
This planned comprehensive inspection took place on 31 January 2019 and was unannounced. We returned on 5 February 2019 to complete the inspection.

What we did:
Before the inspection we reviewed the information we had received about the service, including the previous inspection report and notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we gathered information from:

- Eight people using the service
- Two relatives
- The registered manager
- The deputy manager
- Five members of care staff
- Two members of maintenance
- The housekeeper
- The Chef
- Two visiting healthcare professionals
- One external professional
- Records of accidents, incidents and complaints
- Audits and quality assurance reports
- Four staff records including recruitment practices
- Five people's care records

After the inspection we gathered information from:

- Night staff
- Resident and staff meeting minutes

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
• At the last inspection (published on 22 February 2018), we asked the provider to take action to make improvements on their systems and processes in place to report and respond to incidents and this action has been completed. The registered manager ensured incidents were reported to the local authority where appropriate, and completed regular audits of accidents and incidents to effectively managed risks to people's safety.
• People told us they felt safe at Fairhaven Care Home. One person told us, "It's wonderful here, I feel safe, and it's my home.", and a relative we spoke with said "I know she's safe here 24/7."
• There were appropriate systems in place to protect people from abuse and staff knew how to prevent, identify and report allegations of abuse. Staff told us they could contact agencies outside of their organisation to raise concern and included comments such as "If I was unhappy I would report it to the safeguarding team and you (Care Quality Commission)" and "We have contact numbers on our staff notice board so we know who we could tell if we needed to."

Assessing risk, safety monitoring and management:
• People's care plans had detailed risk assessments in relation to their care needs. Where people's needs had changed risk assessments were updated and supported staff to know what steps to take to identify and reduce risks to people when providing care.
• Where appropriate, people were involved in decisions around risk taking, for example where a person could go out independently there were risk assessments in place to support their rights and freedoms.
• Environmental risks were assessed, monitored and reviewed regularly. These risk assessments included fire safety, the use of bed rails and gas safety checks.
• In the event of a fire people had a personal emergency evacuation plan (PEEP) in place which was easily accessible.
• Where people were prescribed paraffin based creams, risk assessments were in place to identify and reduce risks around safe storage of these creams as these products are known to be flammable when exposed to a source of ignition.
• We looked at the provider's business continuity plan. This provided detailed actions that would be taken in different scenarios, for example in the event of flooding, and how people would be supported to remain safe.

Staffing and recruitment:
• Staffing levels were sufficient to meet people's needs. A relative told us, "There's always staff around and I visit often." We also observed people had access to enough staff to support them to meet their needs.
• Staffing levels were based on people's needs. The registered manager told us staffing levels were flexible to ensure people received the right support. For example, we reviewed staff rotas which evidenced where

additional night staff had been in place in December 2018 to support people's night time needs where people required additional support.
• Safe and effective recruitment processes were in place. There was a clear recruitment pathway with the relevant pre-employment checks including disclosure and barring service (DBS) checks before commencing employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Using medicines safely:
• People received their medicines in a timely manner. Delegated staff supported people to take their medicines and one person who told us, "I have a terrible headache, but they (staff) have given me some tablets so I am starting to gradually feel better".
• People were supported to receive their medicines safely and there were clear systems in place to store, administer and dispose of medicines appropriately.
• Staff responsible for assisting people with their medicines were trained in the safe administration of medicines and underwent competency assessments regularly.
• Where people's medicines were prescribed on an 'as required' basis such as pain relief, protocols were in place which included person specific details on signs and symptoms to be observed.

Preventing and controlling infection:
• The home was clean and tidy and a visiting relative told us "It's always clean and tidy I have no concerns."
• There was clear delegation of cleaning tasks between the house keeper and care staff. The house keeper followed daily, weekly and monthly cleaning schedules to ensure all areas of the home were maintained. This was overseen by regular audits completed by the registered manager.
• Staff received training in infection control and there were infection control champions who shared up to date information with other staff members to keep staff updated with current best practice and guidance.
• Staff had access to personal protective equipment such as disposable gloves and aprons, and we observed staff used these consistently when providing care to people.

Learning lessons when things go wrong:
• The registered manager completed reviews of all accidents and incidents at the home. Information was captured for each person and the nature of incident.
• Information on accident and incident recordings was compiled into visual bar graphs and charts. This supported the registered manager to identify key themes, patterns and trends and reflect on lessons learnt for each incident type. For example, where a person had experienced multiple falls, analysis prompted risk assessments and plans to be updated and encouraged timely referrals to a falls clinic for further support.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Comprehensive assessments of people's care and support needs were completed before people moved into the home, which included people receiving respite or short stays.
• People and their relatives were involved in their needs assessments. A relative told us "The (registered manager) will always call and talk through any changes, we are involved in care planning and decisions."
• Staff were encouraged to keep updated with best practice guidance, and the registered manager supported this by producing "in a nut shell" guidance on legislation and statutory guidance.
• We saw technology used to support people to meet their care needs. For example, there was a call bell system in place and where appropriate some people had pressure activating mats to allow them to have privacy in their rooms whilst maintaining their safety.

Staff support: induction, training, skills and experience:
• Staff had a good understanding of the people they supported and a relative commented "Their expertise is fantastic, I have no complaints."
• Staff told us they felt supported by the registered manager and records reflected that staff received regular supervision, appraisals and personal development plans.
• Staff received a range of training appropriate to their role and new staff were supported to complete a structured induction programme. This was evidenced by reviewing the home's training matrix which recorded what, when and who had attended training sessions.
• The registered manager was passionate in developing staff's strengths and knowledge and encouraged continued learning. For example, staff had opportunities to undertake additional training in areas of interest such as falls prevention and sensory therapies to benefit people living in the home.

Supporting people to eat and drink enough to maintain a balanced diet:
• People had access to appropriate support to meet their diet and nutrition needs. People spoke positively of the food on offer and commented it was, "Simple wholesome food." and "I always enjoy my meals."
• People's care records reflected personal information such as preferences, allergies and support they required. Where people's needs required a modified diet such as soft or pureed foods this was clearly communicated with the chef using an information board. People requiring modified diets also had relevant Speech and Language Therapist (SaLT) assessments and guidelines for staff to follow.
• Where people required additional monitoring of their food and fluid intake we saw daily records were completed. This supported staff to identify any concerns or changes to people's intake quickly so they could respond. For example, where a person's daily record identified a low fluid intake this was communicated with night staff who could continue to encourage drinks.
• Where appropriate, people were able to choose where they would prefer to have their meals for example in

the communal dining area, quiet room or their bedroom.

Staff working with other agencies to provide consistent, effective, timely care:
● Staff worked well with external professionals to ensure people had access to the appropriate health care services. People and relatives told us "The GP is always called out if there's a problem." and "The doctor comes straight here if I'm unwell."
• The Registered Manager discussed the positive relationships the team had built with local stakeholders such as the Clinical Commissioning Group (CCG), hospice and local authority commissioners. The registered manager told us "They know we only contact them when its needed so they come out quickly."
• Where people's care and support needs meant they were cared for in bed, care records demonstrated that appropriate referrals had been made for professionals to visit the home.

Adapting service, design, decoration to meet people's needs:
• Bedrooms were observed to be personalised with people's furniture and photographs displayed and one person commented, "I have a nice bedroom, plenty of room and my things are nicely arranged."
• People at the home had access to a stair lift to support them to move between the ground floor and second floor where appropriate.
• Fairhaven Care Home provides care and support to people living with dementia. The registered manager acknowledged that the physical layout of the building could present a challenge to some people, so adaptations to the colour of toilet doors, hand rails and room layout had been considered to minimise this where possible and promote independence.
• People had access to a secure garden and wheelchair accessible walk way.
• One corridor in the home had been decorated to reflect 'days gone by' and displayed ornaments and visual displays of popular past times. The registered manager told us there was an action plan in place for future improvements which included re-designing existing spaces to create a residents' kitchen and in-door garden.

Ensuring consent to care and treatment in line with law and guidance:
• We consistently observed staff seeking consent from people in daily interactions, for example knocking on doors and seeking permission to enter and before carrying out personal care tasks.
• 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.
• We found where staff identified people who lacked capacity to make certain decisions they consistently followed the principles of the MCA to protect people's rights and freedoms. For example, care records had decision specific assessments of capacity in place for people for decisions such as medicine management, consent to share information and the use of bed rails where appropriate. Where people required action to be undertaken in their best interest records reflected where families or people of importance had been involved in these discussions.
• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Where people had been assessed as lacking capacity to consent to their care and accommodation, we saw appropriate DoLS applications had been made.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care

Ensuring people are well treated and supported:
• We observed people were treated with kindness and consideration by staff. People seemed comfortable in their interactions with staff and each other and a relative told us, "I couldn't wish for anything better the staff are angels."
• Staff were committed to providing person centred care to people and demonstrated a good understanding of people's preferences, interests and dislikes. For example, we observed staff sharing magazines and newspapers with a person and they told us, "(Person's name) can still read headlines and look at pictures so we always have a chat about what's going on as they enjoy it."
• Where people's needs impacted their ability to engage verbally, staff used positive non-verbal communication such as appropriate touch, eye contact and singing to promote meaningful engagement.
• We observed staff engaged people in their care and explained tasks. For example, when supporting a person to mobilise with a hoist staff explained each step of the transfer so the person could anticipate what was happening.
• People's care records were holistic and included information about their history, previous employment and things that were important to them.

Supporting people to express their views and be involved in making decisions about their care:
• We observed staff regularly interacted with people to seek their views and wishes. For example, staff provided choices of drinks, activities and asked where people would like to sit.
• We reviewed records of resident's meetings which were held regularly. The registered manager told us these meetings provided an opportunity for people to be involved in planning future events, be consulted on any changes happening and discuss any concerns people may have.
• Staff were patient and understanding of people's needs, and allowed people time to process information when making decisions. For example, the chef spoke to each person individually in the morning to share the day's menu choices. The use of photo cards of the meals were being introduced to support people's understanding and participation.
• People were supported to be involved in the planning and delivery of their care as appropriate to meet their needs. People received a person centred and comprehensive assessment before going into the service to ensure staff had the right information to offer support.
• The registered manager had a good understanding of equality, diversity and people's rights. We highlighted that care records did not explore some aspects of equality, for example recognising people's sexuality. However, the registered manager told us sensitive discussions were led by the person using a person-centred approach to encourage people to identify "Who is important to them" which they recorded.

Respecting and promoting people's privacy, dignity and independence:

• Staff protected people's dignity. A visiting health care professional we spoke with told us, "Staff always find somewhere private and quiet when we come for people's appointments."
• Where people relied on staff to meet all their support needs, care records ensured staff approaches continued to support people to have choice over their daily routines. For example, one person's care record stated, "It would be nice for a carer to select my clothes and then ask me if I agree."
• Where people could manage or participate in meeting their own care needs staff supported their independence. For example, a person told us "I'm a picky eater but they find something I like, they'll find me an alternative if I don't like it and sometimes if I put an apron on I can help myself."
• Staff described how they supported people to maintain their privacy and dignity. This included using screens where bedrooms were shared, respecting people's choices and using towels to protect people's dignity when supporting personal care.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Where people required reassurance and behaviour management approaches during the inspection staff were observed to be responsive and readily available to offer emotional support. A relative told us, "In the afternoon, mum gets agitated and they find her things to do like wiping with a cloth or folding, anything to occupy busy fingers."
• Where people valued the companionship of animals the registered manager was understanding of the importance of these relationships and people were supported where possible to keep their pets. The provider had also purchased robotic cats as a therapeutic redirection aid that benefited some people to reduce anxiety and agitation. We observed how these comforted people when they became distressed.
• People's preferences were listened to, for example a relative told us, "I brought in some lemon curd as mum likes it and now they always have it here."
• People's care records were reviewed regularly and staff were responsive to people's changing needs. A relative told us, "She's changed a lot in the three years she has been here, they have to do more for her now but they know her really well."
• Where some people's needs fluctuated on a day to day basis staff approaches and care records were responsive to this. For example, we saw a person's care record included information on how to offer support on a "good day, bad day" to reduce risk of falls.
• The provider had a proactive approach to supporting people to maintain their interests and wellbeing through "meaningful activities". The registered manager and staff were working with an external activity and research project to learn new ways of engaging people in everyday tasks. For example, this collaborative working introduced the use of an electronic tablet people could use to access quizzes and reminiscence. Staff told us, "It's great because we can sit with people with all different abilities and find something they like." and we saw this being used.
• Where people's needs meant they received all their care in their bedrooms, staff personalised activities to be inclusive and used sensory and therapeutic approaches to engage people in stimulating activities.

Improving care quality in response to complaints or concerns:
• There was a complaints procedure in place which was displayed in each person's bedroom. Where this process could be challenging for people identified as lacking capacity, the registered manager told us people's families supported them to raise complaints and concerns. The registered manager also told us that where people were subject to DoLS they had contact with people's relevant persons representatives to advocate on their behalf.
• Feedback from relatives we spoke with confirmed they would be comfortable raising any concerns. One relative said, "If there's anything wrong with Mum they call me straight away." and another said, "(registered manager) is always around and I would speak with her if I was concerned. I am sure she would do all she could to address things."

• The registered manager told us they took people's feedback very seriously and investigated all complaints and concerns. For example, we reviewed records of anonymous feedback the service received in March 2018 and actions taken. This included an action plan and subsequent questionnaire sent to all families to seek people's views which was shared with staff to drive improvements.

End of life care and support:
• The registered manager spoke very passionately of their personal and professional values in ensuring staff showed care and compassion in meeting people's end of life care needs. They stated the importance of "Having one chance to get it right, it's one of the most important things you can do for people."
• People's care records for end of life care detailed individual needs, preferences and family wishes.
• The registered manager told us how they had built good relationships with healthcare professionals and the local hospice to ensure people got the right support at the right time.
• Where people and families expressed a wish to remain in the home for as long as possible, care records reflected this and the registered manager ensured anticipatory care plans were in place to support this.
• Staff had all received training on end of life care, and the registered manager had participated in training provided by the local hospice to ensure staff had access to up to date knowledge and skill sharing.
• Although there were no people identified as having any specific cultural needs at the time of inspection, the registered manager discussed how people had been supported since their last inspection to ensure "Care was provided to the best of our understanding to the way they would have wanted it". This included providing staff with a resource file of multiple faiths for example Jewish, Muslim and Christianity and a summary of what might be important cultural aspects to consider when meeting end of life care needs and planning arrangements.

Good

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.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• People and relatives told us the home was well managed and comments included; "I always feel I can go up to the office and have a chat with the manager if I'm worried" and "It's well run really." Relatives' surveys we reviewed also included feedback on the registered manager's "hard work, love and kindness" for people they cared for.
• The registered manager had a good understanding of their Duty of Candour requirements. Staff told us they promoted a culture in the home to be open and honest. For example, one staff member commented "When things go wrong it's important we talk about it, it's no good covering things up or we don't learn from them."
• Staff consistently told us they felt supported by the registered manager and were encouraged to develop their knowledge, skills and interests to provide high quality care. One staff member commented, "I love my job because I am so supported by (the registered manager). People aren't just saying it she really is amazing, you can call her at two o'clock in the morning if you need to for reassurance."
• The registered manager discussed her commitment to providing high quality care and the importance of all staff feeling "valued", having opportunities to progress and leading by example.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was a clear management structure in place which included the registered manager, deputy manager and support from the provider. Staff supervision agreements and notice board included a list of the provider's contact details and staff told us they could share any concerns with them.
• The provider had effective and comprehensive quality assurance processes in place. The registered manager regularly completed a range of audits and daily observations.
• Management and staff were clear about their roles and requirements and communicated effectively to ensure people's needs were met and changes or concerns were shared. One staff member said, "It's a 24/7 role and it only works if we all talk and communicate together, we are all one big team."

Continuous learning and improving care:
• During the previous inspection in December 2017 we identified two breaches of regulations. We told the provider's and registered manager they must make improvements to ensure effective systems were operated to ensure compliance with regulations and to monitor and improve the quality of the service provided. At this inspection we found improvements had been made.
• The registered manager told us they could access support from the provider's quality performance

manager who completed regular service reviews and audits on their performance to drive improvement.
• The home used an electronic tracking system to analyse and keep oversight of accidents, incidents and concerns. This was also accessed by the provider and supported action plans to be developed where these were needed. The registered manager told us "There shouldn't be anything on there that I don't already know about, but it's helpful to have fresh eyes look at things so we can keep improving."
• The registered manager encouraged feedback from people, relatives and professionals through annual surveys. Information gathered from these were used to drive improvements, for example the 2018 survey provided feedback that people were not always happy with their activities. This feedback prompted the registered manager to seek advice and guidance in this area and led to engagement with the National Activity Providers Association to explore new ways of engaging people.

Working in partnership with others:
• A visiting professional told us, "Communication is always really good and we have regular contact with the service" and "They know the people they look after well."
• The registered manager encouraged partnership working and community networking. For example, recent contact with a local church progressed to volunteers coming into the home to engage with residents.
• The registered manager was subscribed for electronic updates with a number of professional organisations and commissioners such as the local authority and Clinical Commission Group. This provided opportunities to attend information days and events to maintain close professional networks.