Mills Family Limited

Fairlight & Fallowfield

Inspection report

Ashfield Lane
Chislehurst
Kent
BR7 6LQ

Tel: 02084672781
Website: www.millscaregroup.co.uk

Date of inspection visit:
16 May 2019
17 May 2019

Date of publication:
04 September 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Fairlight and Fallowfield is a care home made up of two distinct units, a nursing unit and a residential unit. in joined buildings; Fairlight is the residential unit and Fallowfield the nursing unit. The care home accommodates up to 55 people in total. There were 49 people aged 65 and over living there at the time of the inspection.

Why we inspected: This was a focused inspection to follow up on the enforcement action we had taken at the comprehensive inspection in January 2019. It was to see if the provider now met the regulations in the key questions Is the service safe? And Is the service well led? We were also aware of a notifiable safety incident which was being investigated under safeguarding at the time of the inspection and which raised questions about care and treatment provided to people following a fall.

Following the last inspection and the sixth repeat overall Requires Improvement rating we had met with the provider and registered manager with representatives from the local authority on 13 March 2019 to discuss their overall rating and how they might make improvements to meet the regulations. They had provided us with an improvement plan. The inspection was also to review the progress of the improvement plan where it fell under the key questions of safe and well led.

People's experience of using this service:
We found that some improvements had been made and actions taken in respect of some concerns identified at the previous inspection in January 2019. However, other areas had not been acted on or, where they had this had not been in a robust and effective way. We found there was a continued breach of regulations in the way the home was run. There was an absence of effective systems to provide oversight over risks to people following accidents and incidents and in relation to possible risks at the service identified at the last inspection, which had not been fully addressed. There was an absence of effective oversight to ensure adequate records of people's care were maintained.

We also found the provider and registered manager had not met the requirements of the duty of candour regulation which require registered persons to act in an open way following a safety incident about how such incidents have been responded to.

We had mixed feedback from people and relatives about the way the service was run. There was no system to ensure regular checks were carried out on people in their rooms or that staff received and understood communication at handovers or from staff meetings. The service did not proactively seek to include relatives at residents' meetings. Audits and checks were not always effective at identifying issues.

There were no effective systems to assess and review required staffing levels. We have made a recommendation for the provider to seek suitable guidance on deciding appropriate staffing levels.

People told us they felt safe and looked after. Medicines were safely managed. There were effective

recruitment measures in place. The management of people's dietary risks which had been a concern at the previous inspection had improved and communication about these risks was more effective. Kitchen staff had received appropriate training in relation to possible choking risks.

Not all key questions were considered at this inspection and the service remains rated Requires Improvement overall. This will be reviewed again at our next comprehensive inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Requires Improvement report published 12 March 2019.

Enforcement: Full information about The Care Quality Commission's (CQC) regulatory response to more serious concerns found in inspections and appeals is added to reports after any representation and appeals have been concluded.

Action we told provider to take: For further information please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: Following this inspection we wrote to the provider outlining the concerns we had about the management of aspects of the service and asked for a report of actions they would undertake to address the issues found.

We will continue to monitor this and other information and intelligence we receive about the service closely. We will return to re-inspect in line with our inspection timescales for Requires Improvement services or earlier if we have information about new concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Fairlight & Fallowfield

Detailed findings

Background to this 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.

This inspection was a focused inspection planned to follow up on enforcement action taken after the last inspection in January 2019. It was also prompted in part by notification of an incident following which a person sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of falls. This inspection examined those risks and checked to see if the provider had acted to rectify the more serious breaches of regulations identified at the last inspection.

Inspection team: This inspection was carried out by two inspectors.

Service and service type: Fairlight and Fallowfield is a care home that provides accommodation and personal care for older adults. 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 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.

Notice of inspection: This inspection was unannounced.

The inspection site visit activity started on 16 May 2019 and ended on 17 May 2019.

What we did: Before the inspection we reviewed the information we held about the service. This included details about incidents the provider must tell us about such as any safeguarding alerts they had raised. The provider had previously completed a provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority and health commissioners to ask for

their views. We used this information to plan our inspection.

During the inspection we spoke with seven people and four relatives, we also observed the care being provided in the communal areas. Some people were not able to express their views about the care provided; so we used our Short Observational framework tool (SOFI) to help us better understand their experiences of the care they received. We spoke with three care workers, a senior care worker, the housekeeper, two nurses, the clinical lead, the head of the residential unit, the registered manager, the provider and the provider's representative.

We reviewed a range of records including, five care plans and two staff recruitment and training records. We also reviewed records used to manage the service, for example, accidents and incident records, audits and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

- At the last inspection we had found a breach of regulation as possible risks to people in relation to using the stairs at the home had not been identified or assessed. At this inspection on 16 and 17 May 2019, the provider and registered manager had put in place individual risk assessments where people chose to use the stairs. However, there was no clear process to consider the use of suitable control measures to reduce the likelihood of these risks. The registered manager told us they thought people had been offered a call pendant but was unsure if this was the case. The system of oversight of people's safety remained ineffective.
- There was an absence of effective oversight to ensure falls risk assessment tools were completed in line with the provider's policy to ensure that risks were effectively monitored and managed. The policy required staff to review the falls risk assessment after a fall but we found this was not always carried out. For example, for one person who had fallen on 21 April 2019, the next review of their falls risk assessment was several weeks later, on the 14 May 2019.
- We found for another person their falls risk assessment stated they were at risk of falling because of their behaviour, which also posed a risk to staff. However, no guidance was provided to staff on their behaviour or how to manage this risk. There was no evidence of an appropriate referral for support in relation to managing monitoring or reducing these risks.
- At the last inspection in January 2019, we had found improvement was needed with regarding the completion of accident and incident records as these were not always signed off by the registered manager to ensure learning was identified. The registered manager had told us that this would improve under the new electronic system; which would make learning easier to identify.
- At this inspection we found the electronic records of accident and incidents were still not sufficiently detailed to provide an accurate record of people's care. Accident records we reviewed did not consistently include the advice given by health professionals or emergency services when this had been sought, or, the care provided by staff. There was insufficient oversight to ensure accurate, complete and up to date records were maintained.
- Routine checks such as blood pressure, pulse and temperature checks were not always routinely recorded following a fall or accident, in line with the provider's policy. For example, for one person who had a fall on 21 April 2019, their blood pressure was not checked until 25 April 2019 at the request of the GP. These issues had not been identified by the registered manager. Systems to manage the quality and safety of the service were therefore not effective.
- The registered manager or senior staff member reviewed accident reports. However, there was no record of any review or assessment of factors that may have contributed to the incident such as any environmental factors, or footwear to reduce further risk.

The above issues evidenced failures in the systems and processes to assess monitor and reduce the risks to

people's health, safety and welfare and were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks were assessed and monitored such as risks in relation to moving and positioning people, skin integrity and nutritional risks. There was guidance for staff on how to reduce possible risks such as the use of pressure relieving equipment.
● Regular internal checks and external servicing were carried out on equipment and aspects of the premises to reduce possible risks, for example, in relation to water temperatures, window restrictors, fire safety, gas and electrical equipment and installation.
● Staff told us they received regular fire safety training including the use the evacuation equipment, and there were records of regular fire drills. People had evacuation plans to guide staff and the emergency services.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they thought they were safe at the home. One person said, "The staff are very good. I feel very safe here."
● Staff received regular safeguarding training and understood how to safeguard people from possible harm or abuse and the action to take if they had any concerns.
● We were aware of an ongoing safeguarding investigation in relation to a fall, which was still being investigated at the time of the inspection. The provider was cooperating in the investigation and they and the registered manager understood how and when to raise safeguarding alerts.

Staffing and recruitment
● At the last inspection we had found there were enough staff to meet people's needs. At this inspection we found this was not consistently the case and required improvement to ensure people's needs could be met.at all times
● Most people told us they thought there were enough staff available to meet their needs and that their call bells were answered promptly. One person told us, "There are enough staff, if I use my call bell, someone will always come and find me." However, another person said their call bell was not always promptly answered and a relative told us they thought there were not always enough staff available.
● On the first day of the inspection we found the staff on duty matched with the rota and there were no agency staff in use. Call bells were attended to promptly and we did not see anyone waiting for support. On the second day the nursing unit was two staff short of what had been planned for. The registered manager had requested agency staff to attend but they did not arrive until over two hours after the shift started. This impacted on people's care as we found people were waiting for their personal care throughout the morning.

● We spoke with the registered manger about how staffing levels were decided. They told us they did not currently use a dependency tool to assess the staffing levels as they had not found one suitable. At the last inspection in January 2019 the registered manager had told us they used the findings from call bell audits to asses staffing levels. However, at this inspection we were told these had been discontinued as response times were no longer an issue. The registered manager was unable to explain how staffing levels were assessed and decided.

We recommend the provider seeks advice from a reputable source on assessing appropriate levels of staffing at all times.

● Recruitment procedures complied with requirements and reduced the risk of employing unsuitable applicants. Staff recruitment records included completed application forms, full employment histories and

evidence that all necessary checks had been carried out

Using medicines safely

● Medicines were managed safely. People received their medicines as prescribed. Medicines administration records were completed correctly. Any allergies were highlighted on people's records. Controlled drugs were stored and managed in line with guidance and legal requirements.

● Medicines were stored safely. There was guidance in place for staff on when to offer people 'as required' medicines to ensure people received their medicines at appropriate intervals

● Staff told us they received regular training on how to administer medicines safely and understood what to do if an error occurred to reduce any possible risks.

Preventing and controlling infection

● The environment was clean and free from odours. We saw hand wash facilities and dryers in communal toilets and hand sanitisers were available to reduce infection risk.

● People told us and we observed staff used personal protective equipment such as gloves and aprons appropriately. Staff were aware of the importance of good food hygiene, how to reduce the risk of infection and regular cleaning was carried out on equipment.

● Housekeeping staff said there was always plenty of cleaning materials available and there were enough of them to carry out their roles.

● There was a legionella risk assessment in place to reduce possible risks. The environmental health agency had inspected the kitchen on 8 March 2018 and awarded the home the top score of five.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

- At the last inspection in January 2019 we took enforcement action as systems to monitor the quality and safety of the service and systems to assess and reduce risk were not operated effectively. At this inspection we found while some improvements had been made, other areas had not progressed and lacked effective management and oversight.
- At the last inspection of the service, it was identified there was no environmental risk assessment for the flights of stairs at the location to ensure potential risks were assessed and minimised. At this inspection we found this remained the case and some possible risks had not been assessed.
- Where people were living with dementia and may lack capacity to decide about the safe use of the stairs, there was an absence of a clear system to give full consideration of all possible risks. Minutes from recent heads of department meetings following the last inspection, showed some measures had been put in place to reduce risk at night, with a sensor mat, but this did not address potential risks throughout the day.
- The provider and registered manager had identified some learning from recent safeguarding investigations and reviewed their procedures in relation to falls and accidents. However, there was no guidance in relation to the reporting of near misses. This meant possible learning to reduce future risks may not be identified
- The new procedures failed to provide staff with guidance on the observation or oversight of people following a fall. This posed a risk to people's health and welfare that any deterioration following a fall may not be identified in a timely way. There were no records of any observational checks on people after falls. There was no effective oversight of people following an accident or incident to monitor people's health, safety and welfare.
- Where people spent much of the day in their rooms there was no effective system of regular oversight or checks on their safety and welfare. We saw people had call bells however these were not always within reach during the inspection. This meant if they had a fall or felt unwell there was a risk they would not be attended to in a timely way.
- Staff told us they were alerted to changes in people's condition via the handover meeting. However, no records were kept of these meetings to ensure that information about people's care and treatment had been passed to and understood by all staff.
- At the last inspection we had found an absence of systems to ensure there was oversight of people's complex health needs and risks to help identify any deterioration. At this inspection we found this continued to be the case. Heads of Department meetings had been put in place to aid communication across the service. However, minutes of these meetings showed while wider clinical issues, such as the new falls guidance, were discussed; there was no inclusion of a review and oversight of individual people's complex or

changing needs.
● Monthly care plan audits had been introduced to check care plans reflected people's needs. However, these audits did not include a check on the accuracy of the completion of risk assessments or consideration if suitable control measures were in place to reduce risk. We identified an issue with the completion of a dietary risk assessment tool which meant the level of risk was not accurately recorded. This had not been identified through the audit process and had been a concern at a previous inspection.
● Aspects of the quality monitoring processes were not effective at consistently identifying areas for improvement to the quality and safety of the service. Spot checks on night staff which had not been in place at the last inspection, had still not been completed to reassure the provider about the standard of care provided at night. There was no formal process to review staffing levels to ensure they remained adequate at all times.
● An infection control audit of the nursing unit signed by the registered manager on 1 May 2019 had not identified an infection control risk with a bed rail bumper which we found at the inspection. The infection control auditing process was insufficiently robust as it did not include the monitoring of infection control processes such as hand washing, the laundry infection control cycle, cleaning and condition of equipment including pressure relieving equipment, the management of infections or food hygiene and handling arrangements.
● Medicines audits did not always record the issues identified fully enough for them to be addressed. One medicines audit dated 31 January 2019 referred to six gaps in the MAR charts but no reference to where these gaps were or that this had been investigated to ensure medicines had been administered appropriately. There was no record to show this had been followed up by the registered manager.

The above issues evidenced a continued failure to effectively monitor the quality and safety of the service or to mitigate risks to people's safety and welfare. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had been served with a fire enforcement notice on 16 April 2019, requiring them to comply by 15 October 2019. We had requested an action plan in April 2019 which had been provided. We checked and found that the actions identified as completed, had been carried out and work was in progress to complete the actions required.
● Some improvements had been made. Some steps had been taken in relation to the assessment of risks for the stairs. At the last inspection in January 2019 we found the system of oversight of people's dietary needs was not effective. Guidance from health professionals such as speech and language therapists (SALT) was not always available and communication with the kitchen needed improvement. At this inspection we found kitchen staff had received training on dysphagia so that they were aware of how to reduce possible choking risks. They were provided with people's dietary requirements and had copies of SALT guidance.
● Where people were nursed in bed they had copies of SALT guidance available in their rooms to remind staff about their needs. We tracked that people received the right dietary consistency at meal times in line with the guidance from health professionals.
● We found where one person had capacity to decide about their diet and refused to follow the guidance of health professionals this was not clearly recorded. We discussed this with the registered manager who advised us the records would be updated.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
● The registered manager was unable to locate the duty of candour policy when we asked for it. This was sent to us by the provider's representative. We asked the registered manager and provider for evidence of how they had met this regulation and their policy in respect of notifiable safety incidents. This regulation

requires provider's and registered managers to act in an open and transparent way in relation to care and treatment provided. No information was offered to us during the inspection to evidence how this regulation was met.

● Following the inspection, the provider sent us details of some communication they had with relatives. However, this did not evidence that a full account about incidents was provided in a timely way or in writing or an apology provided in line with the regulation.

This was a breach of Regulation 20 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 had mixed feedback from people and relatives we spoke with about the management of the service. Two relatives told us that they thought the care staff were 'good' and 'worked hard' but, the management of the service was not responsive or approachable.

● At the last inspection we had found while the provider sought feedback from people and relatives through surveys and residents' meetings; relatives did not always get advanced notice of the meetings and were not always aware when they were. At this inspection relatives told us this remained the case and that they did not receive minutes from meetings. This required improvement to ensure that relatives could represent or support their family member at meetings and be updated about future changes. Minutes from residents' meetings in the residential unit on 16 January 2019 and 9 April 2019 showed no relatives were present at either meeting.

● We found improvements had been made through the introduction of action plans from the feedback at residents and staff meetings to ensure they kept track of issues.

● Most staff told us they thought the service was well run. They said the registered manager was supportive and approachable and was visible in the home. Staff meeting minutes showed that not all staff were present at staff meetings. We asked the registered manager confirmed staff were not sent copies of the minutes of meetings to be updated about changes. This meant opportunities to learn about best practice and learning were missed

Working in partnership with others

● The service communicated with a range of health professionals and other agencies to provide appropriate care. We saw appropriate referrals had been made through the GP.

● However, we found some improvement was needed for one person who was receiving support from visiting health professionals for wound care. There was no information about the support being provided in their care plan to guide staff on how to identify any concerns, or, if there were issues they needed to be aware of that might affect the personal care provided. We discussed these concerns with the registered manager who agreed to investigate them.

Following the inspection, we wrote to the provider outlining the concerns we had about the management of aspects of the service and asked for a report of actions they would undertake to address the issues found.

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 Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider and registered manager did not always act in an open and transparent way or in line with this regulation following notifiable safety incidents. Regulation 20 (1)(2)(a)(b)(3)(a)(b)(c)(d)(e)(4)(a)(b)(c)(d)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to assess, monitor and improve the quality and safety of the service and monitor and mitigate risks to people's safety and welfare were not always effectively operated. Accurate complete and contemporaneous records of people's care were not always maintained. Regulation17(1)(2)(a)(b)(c)

The enforcement action we took:

We served a notice to impose conditions on the provider's registration to require them to submit reports of actions taken to address the concerns found.