Fairhaven Healthcare Limited

Fairhaven Healthcare Ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Fairhaven Healthcare Limited is a domiciliary care agency. It provides personal care to people living in in the community. At the time of inspection Fairhaven Healthcare Limited was providing personal care to 37 to people in their own homes.

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

People's experience of using this service:
Risks to people were not always effectively identified and managed to ensure people were appropriately protected.

Medicines were not always safety managed in line with best practice guidance. The provider had failed to make adequate improvements since the service's last inspection.

The provider had limited quality assurance processes in place to monitor the delivery of people's care. We found these were not always effective or robust to identify and drive improvements.

We received mixed feedback from people that their care was delivered at the preferred time to meet their needs. We have recommended the provider review their care call schedules.

The provider's recruitment practice did not always ensure new applicants provided a full employment history.

We received mixed feedback from people and their relatives about being involved in the planning and reviewing of their care.

People's rights and freedoms were not always protected. Where people were considered to lack capacity, systems and processes did not always reflect compliance with the principles of The Mental Capacity Act 2005.

People told us staff were caring and supported people to maintain their privacy and dignity.

Morale amongst staff was positive and staff told us they felt supported in their role by the general manager.

Rating at last inspection:
This service was previously rated as requires improvement at the last comprehensive inspection and found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. That report was published on 22 May 2018.

Why we inspected:

All services rated requires improvement are re-inspected within one year of our prior inspection. This was a planned inspection based on the previous inspection rating.

Enforcement:
We found breaches of four regulations at this inspection. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:
Until the provider can show they are compliant with the fundamental standards in the regulations, we will continue to monitor the provider's progress in line with our published protocol for services rated requires improvement. These procedures will include meeting with the provider and requesting an agreed improvement plan with timescales.

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 effective?

Requires Improvement

The service was not always effective

Details are in our effective findings below.

Is the service caring?

Good

The service was caring

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our well-led findings below.

Fairhaven Healthcare Ltd

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 adult social care inspector 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 Healthcare Limited is a domiciliary care agency. It provides personal care to people in their own homes which included people living with dementia, mental health needs, physical disabilities, sensory impairments and older adults and younger adults.

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. During the inspection period the registered manager was not available, however we spoke with the general manager who was delegated responsibility for the daily running of the service.

Notice of inspection: This inspection was announced, and we gave the provider 24 hours' notice of the inspection activity as we needed to be sure staff would be available. Office location visits took place on the 8 and 14 May 2019 to speak with the general manager, review care records and policies and procedures. This also included visits to two people's home on 14 May 2019 with their permission, accompanied by the general manager. Telephone contact with people and their relatives who use the service was completed on 9 May 2019 to gather feedback of people's experiences of the care and support provided.

What we did: Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the 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.

During the inspection we gathered information from:

Ten people using the service
Four friends and relatives of people using the service
The general manager
Four members of staff
Audits and quality assurance reports
Medicine Administration Records (MARS)
Three staff records including recruitment practices
Care records for five people

After the inspection we gathered information from:
Telephone contact with two care staff

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.

Assessing risk, safety monitoring and management:
• People's risk assessments did not always contain accurate or up to date information. For example, we found one person's environment risk assessment was incomplete and another person's medicines risk assessment was partially completed. Therefore, we could not be assured that people's care was always provided in a way that recognised potential risks and staff had appropriate information on steps to take to reduce risks to people.
• Where people were identified to have additional risks around managing their skin integrity, care plans and risk assessments did not include sufficient information on steps to be taken to manage and reduce potential risks to people of developing pressure ulcers.
• Where information for staff on the signs and management of sepsis for a person had been left by a district nurse, this information was not clearly communicated to the general manager. As a result this person's care plan was not updated to reflect additional risks, signs and symptoms for staff to monitor and take prompt action.
• Guidance for the management of risks associated with people's safety was not always sufficiently detailed to mitigate the risk of harm. For example, where a person had a wrist pendent alarm to maintain their safety at home, we observed staff failed to ensure the person had this on before leaving the care call. Information was not available in the persons care plan to ensure staff knew this equipment was in place or what support the person required to use it.
• Where people required additional moving and handling equipment, risk assessments did not always detail person specific information such as sling size, type or positioning to ensure staff were aware how to use this equipment safety.
• We were told by the general manager four people were prescribed the use of bed rails to maintain their safety when in bed. The use of bedrails can present additional risks to the person's safety such as a potential increased risk of entrapment of the body or limbs. However, there were no additional risk assessments in place to ensure consideration of people's safety when using bed rails. The general manager was not aware this was required and following our feedback took steps to address this.
• One person's records kept at their home did not contain copies of risk assessments completed such as such as medicines management and moving and handling risk assessments. This meant there was a potential risk that the person could receive unsafe and inappropriate care, as care staff did not have immediate access to this information.

The failure to consistently assess and take all reasonably practicable steps to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:

• At the previous inspection we found that medicines were not managed safely. Practices did not follow The National Institute for Health and Care Excellence (NICE) guidance in relation to managing medicines for adults receiving social care within the community. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we told the provider to make improvements.
• At this inspection we found medicines continued to not always be managed safety.
• People's medicine administration records (MAR) were kept in their home. Staff administering medicine are required to initial the MAR to confirm the person has received their medicine. We reviewed MARs for two people and found gaps in the recording of staff signatures, therefore we could not be assured people had received their medicines as prescribed.
• Where people were prescribed their medicines on an 'as required' basis such as pain relief or topical creams, the general manager confirmed there were no protocols in place to guide staff to know why, when or how this should be administered. This meant people were at risk of receiving or not receiving their medicines as prescribed.
• Where a person was assessed as lacking capacity to manage their medicines safely, we found insufficient consideration of risk management to ensure medicines were always stored safely.
• Where people were prescribed paraffin based creams, there were no risk assessment in place to identify and reduce the risks around safe storage and application of these creams, as these products are known to be flammable when exposed to a source of ignition.
• People's medicine care plans did not always contain up to date or accurate information about their needs and the support required. For example, one person's care plan detailed staff provided them with 'prompting' to take their medicines, however observations identified full support was required due to the persons care and support needs.
• Most staff received training in medicines to support them in their role, however two staff had not completed this and the general manager told us they were 'in progress'.

The failure to take action to improve the safe and proper management of medicines was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:
• We received mixed feedback from people that care calls were timely to meet their needs.
• Some people felt staff were prompt, and told us, "yes I find them reliable and on time" and "[staff are] always bang on time, I'm being well looked after."
• However more than 50% of people we spoke with told us they experienced late care calls which meant they did not always receive the support they needed. Comments included, "sometimes we've had to cancel if the carer isn't on time and I have to get to the hospital" and "sometimes my neighbour has to do my lunch if they are very late."
• We looked at the staff weekly rotas and found that they did not include staff travel time between people's care calls.

We recommend the provider reviews the organisation of their call schedules and takes action to ensure people receive support in a timely way to meet their needs.

• We reviewed the recruitment process and found it was not always effective to ensure all the required checks were completed before staff were employed.
• For example, two of the three staff record's we looked at identified the provider had failed to ensure they sought a full employment history, provide a written explanation for gaps in their employment history or sought information around their health and capabilities to fulfil their role. The provider's recruitment lead told us they thought employment history was required for five years and said they would update

information sought from new applicants in the future. Therefore, legal requirements were not always met, which created a potential risk of unsuitable staff being recruited.

The failure to comply with the legal requirements was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We saw that new staff underwent disclosure and barring service (DBS) checks before starting employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Systems and processes to safeguard people from the risk of abuse:
• People and relatives we spoke with told us they felt the care provided was safe. For example, one person told us, "I feel perfectly safe with the carers."
• Staff we spoke with knew how to raise concerns with the general manager and external agencies such as the local authority to keep people safe.
• We saw information and contact numbers for the local authority safeguarding team was clearly displayed in the office area for staff.
• There were processes in place to minimise the risk of abuse.

Preventing and controlling infection:
• Staff had access to personal protective equipment such as disposable gloves and aprons. Staff we spoke with said supplies of this equipment were readily available from the office.
• Staff's use of personal protective equipment was monitored during spot checks completed by senior staff at people's homes.
• Staff received training on infection control and best practice guidance to support them to prevent the potential spread of infection.

Learning lessons when things go wrong:
• The general manager reviewed individual accident and incident records to identify lessons learnt or improvements required to people's care and made recommendations. For example ensuring staff underwent competency checks following a medicines administration error.
• However, there was a lack of monitoring and evaluation of all accidents and incidents together to enable the provider to identify and respond to potential themes or patterns to drive improvement across the service.

Requires Improvement

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance:
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 reviewed records that documented some people were considered to lack capacity. We found assessments completed were not decision specific and instead listed a range of tasks or activities in a tick box format.
• Where people had been assessed as lacking capacity in one or more areas, including people's ability to provide informed consent to their care, the provider failed to identify where decisions had been made or considered to be in peoples best interest.
• We also found where people were identified by the general manager to be supported to make decisions by relatives or important people through enduring or lasting power of attorney, copies of appropriate documentation was not in people's care files. Therefore, the provider could not be assured that records held lawfully permitted others to make decisions on behalf of the person.
• Following feedback, the general manager took immediate action to review MCA guidance and told us they would review the current recording tools used to ensure future compliance.

The failure to act in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Where people were able to give informed consent to their care and treatment, we saw care records included people's signatures to confirm they were in agreement with their care plan.
• We observed staff verbally sought consent from people before providing care during home visits.
• A person told us, "Yes they [staff] ask me before they help me."
• A relative said, "They [staff] always ask [relative], can they put the cream on."

Staff support: induction, training, skills and experience:
• Staff told us they felt supported by the general manager and they could seek advice and guidance when this was required.
• When staff were recruited the general manager ensured new staff had shadowing opportunities with more experienced staff. The general manager told us this was flexible to support staff to feel confident in their role.

• Staff consistently told us they had access to a range of training to support their role.
• Staff training records confirmed people had completed a range of training relevant to their role.

Supporting people to eat and drink enough to maintain a balanced diet:
• Overall, we received feedback from people that they were not always happy with the support provided around meal times.
• One person told us, "There's not as much tea as I'd like, I only get one in the morning and one at night if I'm lucky and they can't make one at the start and end of the visit, there's not enough time."
• Another person said, "They're [staff] supposed to make me a lunch at 9-10am and leave it in my fridge for me, if they don't come on time I have to get help from a friend."
• However, one person told us, "They offer me a choice of food, I have plenty in the fridge."
• Where a person had food and fluid monitoring records, we found these had not been completed since March 2019. A staff member told us this was a result of not having new charts at the persons home to complete. The general manager was not aware of this and said staff should inform the office when more records were needed.

Staff working with other agencies to provide consistent, effective, timely care:
• The general manager told us they worked in partnership with district nurses, occupational therapists, pharmacies and GP's to meet people's needs. However, where advice and information had been given from professionals this was not always noted in people's care files for staff to refer to.
• For example, where a person had input from an occupational therapist to review appropriate use of moving and handling equipment, outstanding actions had not been followed up. Care records did not include information shared at the review about interim measures available to support the persons mobility needs. Following our feedback, the general manager confirmed actions would be followed up with the relevant professionals and care records would be updated to reflect guidance given to support the persons mobility needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• The general manager and senior staff completed assessments of people's care and support needs before care was provided.
• When people were new to the service temporary care plans were put in place which outlined people's basic information, care and support needs and their preferences. This information was then incorporated into more detailed care plans.

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:
• People consistently told us they felt that staff were kind and caring. For example, one person said, "they're lovely, I get on with all the girls" and another person told us, "you can't make it [staff] any better."
• The general manager was observed to be caring and attentive and had established a good rapport with people. The general manager told us they regularly supported people's care calls and knew people who used the service well.
• Staff we spoke with were positive and said they enjoyed their caring role. For example, one staff commented, "I try to think about people's situation, if you love your job then you give good quality, I think how I would like my family to be treated."
• People were supported by staff who were compassionate. For example, a staff member told us how they had picked flowers from a person's garden as they could not easily get outside anymore.

Supporting people to express their views and be involved in making decisions about their care:
• Some people we spoke with felt staff consulted with them around their care and support planning.
• We received comments from people such as, "I give my feedback through the carer", and "we get asked what we want, [general manager] phones and has a chat, they will listen."
• We saw people's care plans included their individual likes and dislikes and information on how they would like to receive their care.
• Care plans directed staff to support people to make choices, for example one care plan stated, "Ask [person] what she would like to wear."

Respecting and promoting people's privacy, dignity and independence:
• People told us staff treated them with dignity and respect when meeting their care needs. Comments we received included, "it's not very nice having to be washed but they [staff] do it well" and "I feel my privacy is respected, the [staff member] who helps me is very good."
• People's care plans considered people's dignity, for example we saw information included directions for staff to "maintain dignity and ensure [person] is covered with a towel when possible."
• A person told us staff promoted their independence and said, 'In the shower I do my front, they [staff] do the back."
• A relative told us, ""yes [staff encourage independence], they try to get [relative] to press the button on the stair lift."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People told us their care plan information was not always accurate to reflect their current needs.
• One person told us, "Reviews are not happening. [staff member's name] has been round, but my file is still incorrect at the moment." A relative commented, "Reviews could be more in-depth."
• Another person said their care plan hadn't been updated to ensure staff had their home access information which had led to missed care calls. They told us, "I've asked them to update it several times."
• We found information in people's care records about the management of risk and their care needs was not always accurate and up to date to reflect the level of support they required. Further details of this can be found under the Safe section of this report.
• We saw staff recorded the care provided to people during care calls, and a person told us, "They use a communication book to tell each other what they have done so they can all look after me."
• Daily recordings for a person also included regular contact had been made with the district nursing team, where further support was required to manage their dressings.
• Where the general manager and staff felt a person required additional support, steps were taken to source an additional care call to support staff to meet their needs.

Improving care quality in response to complaints or concerns:
• There was a complaints procedure in place and written information was available as part of people's care records kept in their home.
• Most people we spoke with told us they would seek support from family or contact the office to raise concerns if required.
• Where complaints had been raised, we received mixed feedback that people were happy with the outcome.
• One person's representative said the general manager was responsive to feedback. They told us action was taken quickly to resolve their concerns following a discussion with the general manager.
• Another relative told us they were not happy with the lack of communication when they raised a complaint. The general manager told us they were aware of this person's concerns and would be contacting them when they had more information.

End of life care and support:
• The provider did not currently have any people receiving end of life care. People's care records did not include information on end of life planning, arrangements or wishes. The general manager told us care plans would be updated with this information when required.
• We discussed with the general manager how they would support people at the end of their life. The general manager confirmed they would work closely with other professionals such as the local hospice and relevant healthcare professionals to ensure people's palliative care needs were met as appropriate.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• At the last inspection we found the provider did not always operate effective systems to monitor the quality and safety of the care provided. At this inspection we found the following:
• There was a general manager in place who maintained oversight of the day to day running of the office and care staff, however there was little evidence to demonstrate the registered manager had similar oversight of the service.
• The provider had limited quality assurance processes in place to monitor and review the overall delivery of people's care and the service provided.
• We found systems were not always in place to provide monitoring and oversight or were not effective or robust to identify and drive improvement and ensure compliance with the requirements of the regulations.
• For example audits of people's care files were not robust in identifying the issue's we found. The provider's care planning auditing process failed to ensure all care records were up to date and accurate to ensure people received safe care and treatment to meet their needs.
• The general manager told us medicines audits were completed monthly, however no audits had been completed since December 2018. Medicines audits were not effective in identifying the concerns we found at this inspection or ensuring medicines were managed in line with best practice guidance.
• The audit for medicines completed in December 2018 highlighted MAR charts were not always completed, and staff signatures were missing, however there was no evidence action had been taken to address this. This meant that audits were ineffective in ensuring that people received their medicines as prescribed.
• Information on staff training was not up to date and accurate. This meant people were at potential risk of receiving care and support from staff who were not suitably trained. As a result of our feedback, the general manager took immediate action and updated the staff training matrix.
• Staff recruitment systems in place did not always ensure all the required recruitment practices were completed.
• Complaints received by the service were kept in people's individual care records and not held or reviewed centrally. This meant the provider could not keep oversight or identify themes or patterns of concerns raised, or provide a systematic response to drive improvements in the delivery of people's care.

The failure to operate effective systems to ensure compliance with regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

• We received mixed feedback from people around their communication with office staff. One person told us, "The girls in the office are very kind and helpful, I phoned to ask for the same carer as she's so helpful and they kept her for me."
• However, another person said, "I've been asking for an earlier call, I don't feel they are listening."
• The general manager acknowledged that it was difficult to provide everyone with the timings of care calls that they wanted but told us that they continually strived to ensure people had consistency in staffing where possible.
• The general manager had a good understanding of their duty of candour requirements. The duty of candour sets out actions the provider should follow when things go wrong, including making an apology and being open and transparent.

Continuous learning and improving care:
• We reviewed records where people received spot checks from senior staff to observe and review the care provided to people in their homes. The general manager told us these visits were used to ensure staff were supporting people in line with their care plans and to make improvements to the delivery of people's care.
• For example, on 10 May 2019 a spot check record identified staff were not observed to read the person's care file. This prompted the general manager to discuss with the staff member their knowledge of the person to ensure they knew them well and what support was required.
• The general manager showed us there had been a new format put in place for seeking people's feedback. This included visual aids via smiley faces as a prompt to help people with communication difficulties express their views. People were encouraged to provide feedback during spot check visits, however these findings were not collated to identify broader patterns or themes to drive improvement across the service.

Working in partnership with others:
• The general manager told us they encouraged positive working relationships with healthcare professionals and local authority commissioners.
• The general manager told us they were keen to gain knowledge from other organisations and agencies and share learning with the team to support good quality care being delivered.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Where people were identified as lacking capacity, decision specific assessments were not always in place to demonstrate where actions were taken in people's 'Best interest'. Regulation 11(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider failed to operate effective quality assurance processes to monitor and improve the delivery of care provided to people and ensure compliance with regulations. Regulation 17(1) & (2)(a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:
The provider failed to ensure the legal requirements were always met in the recruitment of new care staff.

Regulation 19(2)

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Medicines were not effectively managed to assure people's safety. People's risks were not always assessed. Support plans were not always sufficient to ensure staff provided safe care. Regulation 12(1) & (2)(a)(b) & (g)

The enforcement action we took:

We have issued the provider with a Warning Notice.