Fairfield House Healthcare Limited

Fairfield House Residential Care Home

Inspection report

Fairfield House
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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
Fairfield House Residential Care Home is a residential care home providing personal care to 27 people aged 65 and over at the time of the inspection. The service can support up to 36 people.

People's experience of using this service and what we found
People lived in a home that had been through changes in leadership. There had been three different managers of the service in the year prior to our inspection. The acting manager had been in post since mid-November 2021.

The oversight of the home had not been sufficient to ensure people received safe care and treatment.

There was mixed evidence regarding how well risks were managed in the home. We identified positive examples of how risks were identified and managed, however we found examples where risks were not sufficiently monitored and mitigated. The acting manager took steps to address these shortfalls.

People were supported by staff who understood how to reduce the risk of cross infection. Staff mostly wore PPE appropriately the acting manager addressed issues identified during the inspection immediately. One person told us, "They always wear their masks."

There were enough staff deployed to meet people's needs. The staff team was well established with the majority of the team having worked in the home for a sustained period of time.

Relatives were confident in the care provided for loved ones.

People were being supported to see visitors safely, and to go out with friends and family in line with current government Covid-19 guidance. The manager was seeking to encourage the role of essential care givers. Essential Care giver status is given to a relative or friend in order that they can provide enhanced emotional or physical support to a person to ensure their well-being. Essential care givers are subject to the same testing regime as the staff in the care home and can visit more frequently and for longer to provide the identified support.

People told us they felt safe and we saw that they were relaxed in the company of staff. People were supported by staff who understood how to identify and report safeguarding concerns.

Staff supported people to eat and drink well during the inspection. Where people were at risk of not eating and drinking safely or were at risk of not eating and drinking enough, staff liaised with appropriate professionals.

A healthcare professional spoke positively about the way the staff monitored risks associated with people's

well-being and followed guidance.

The management team was responsive to the feedback throughout our inspection.

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

Rating at last inspection
The last rating for this service was good (published March 2018).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to Covid-19 and other infection outbreaks effectively.

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the management of risks. A decision was made for us to inspect and examine those risks.

We inspected and identified concerns with the management of risk, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fairfield House Residential Care Home on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe findings below.

Fairfield House Residential 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out the inspection.

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

The service had a manager registered with the Care Quality Commission; however, they were no longer managing the home. They had left their post on 15 November 2021. A registered manager 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.

What we did before inspection

We reviewed information we had received about the service since the last inspection, this included notifications made by the service and concerns raised with the Care Quality Commission. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection
We visited the service at two different times of the day; this included a daytime visit and an evening visit. We spoke with five people who used the service about their experience of the care provided. We spoke with five members of staff including the acting manager.

We reviewed a range of records. This included elements of eight people's care plans and care records. We looked at a variety of records relating to the management of the service.

After the inspection visit
We continued to seek clarification from the provider to validate evidence found. We spoke with five further members of staff and received feedback until 11 January 2022. We spoke with a representative of the provider who was one of the owners. They were the nominated individual for the service at the start of the inspection however this role was transferred during our inspection. We also spoke with a visiting health professional.

We asked the provider to share a poster asking staff and family and friends to contribute to our inspection. We received feedback from the relatives of four people living in the home.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant 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

● We found mixed evidence in relation to the management of risk. People were not always protected because risks to them were not sufficiently assessed and there were not clear plans of care in place to mitigate those risks. For example, A person was at risk of falls. Staff did not have clear guidance about the supervision they needed when walking as there was conflicting information in their care plans. The motion sensor outside this person's room had not been working effectively. Staff were not aware that the sensor in use indicated a different room on the call panel. This meant the person was able to get downstairs without their mobility equipment or staff support and supervision. An inspector found the person on the stairs, they were asking for assistance. We discussed this with the acting manager, and they arranged for the person to move to a ground floor room.

● A visit from the fire service had identified areas that required action to ensure compliance and a fire safety order had been sent to the provider. This included work required to ensure the safety of the environment and changes to the evacuation procedure. The service had been given until 21 January 2022 to achieve compliance. The acting manager had started to address the issues identified.

● People were supported by staff who had not all refreshed their training related to safety appropriately. This included training related to fire safety and supporting people to move safely. The manager acknowledged this and shared plans as to how this training would be delivered.

There was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks people faced had been assessed appropriately and there were plans in place that staff understood and followed. For example, the risks a person faced related to their nutritional intake had been assessed and they were supported to eat and drink safely.

● A health practitioner told us that risks associated to people's health, such as skin integrity and nutrition, were raised appropriately with them by staff and that guidance was followed. A relative described how staff had acted appropriately to ensure their loved one's safety after an accident.

Learning lessons when things went wrong

● There were systems in place to review incidents and accidents to ensure trends could be identified and acted upon. These had not been completed for three months prior to our visit due to change in management and management capacity. The team discussed any incidents and accidents informally to

ensure that any obvious actions could be taken to reduce the chance of reoccurrence. For example, an emphasis had been placed on staff presence in the communal lounge and we saw this was maintained.

Preventing and controlling infection
● We became assured that the provider was using PPE effectively and safely due to the responsiveness of the manager.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People who could communicate their views with words told us they felt safe. One person told us "I definitely feel safe here." Another person told us "They do their best. I do feel safe."
● Some people living in the home no longer used words as their main means of reliable communication due to the progression of their dementia. We observed people were relaxed with staff throughout the home. Staff interacted in a kind and friendly manner and they made sure people were observed and kept safe.
● Most staff had received training in safeguarding and staff told us they understood their responsibilities to raise safeguarding concerns appropriately. The manager had clear plans in place to ensure all staff updated their training.

Staffing and recruitment
● People were supported by sufficient numbers of staff to maintain their safety and meet their needs. On both occasions we visited there were enough staff to support people. When people requested help, they received this promptly.
● There were enough staff to support people with food and drinks. At lunch time we saw that staff encouraged and helped people with their meal.
● The manager explained they were in the process of recruiting more staff to enhance the flexibility of the team.
● The manager described robust recruitment processes these included checks on the suitability of candidates to work with vulnerable people.

Using medicines safely
● People received their medicines as they were prescribed. They were supported to take their medicines by trained staff.
● Medicines were stored safely and securely, and the oversight of medicines administration reduced the risk of errors.
● We looked at a sample of medicines administration records. These were well completed and signed for when administered or recorded as refused. This enabled the effectiveness of prescribed medicines to be monitored.

● One person received their medicines covertly. This means their medicines were administered to them without their knowledge. An assessment of capacity had been carried out and a best interest decision had been made in partnership with the person's GP, pharmacist and family. The person's care plan gave details of the medicines which could be given in this way.

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.

At the last inspection this key question was rated as good. At this inspection this key question deteriorated to requires improvement. This meant the 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; Continuous learning and improving care

- People lived in a home where there was no registered manager actively running the home although two managers who had left the home remained registered with the Care Quality Commission (CQC). Since the inspection CQC have initiated their deregistration. There was a manager appointed to run the home at the time of our inspection they had not started the put in an application to be registered with the CQC.
- Provider oversight had not ensured the safe running of the home. The provider had not ensured they had the information necessary to maintain robust oversight. Whilst the provider had maintained contact with the home, the weekly return from the home to the provider had not been completed consistently. This return was a form designed to give the provider information about the running of the home. The form did not ask for sufficient information to enable the provider to review the quality and safety of care provided and contact with the home had not covered these areas. For example, the provider was informed about training booked and completed but did not retain oversight of any training that was overdue. They had not received sufficient information to enable them to ensure all fire regulations were met.
- Management oversight had not ensured that systems designed to ensure people's safety were embedded. A handover record was not used effectively to ensure staff understood the risks a person was facing with their mobility. Some care records had not been reviewed and updated to ensure that staff had access to current risk management information. For example, one care plan said the person had a sensor in their room to alert staff when they were moving around during the day and night. However, this person had bedrails so would be unable to move around. They also had a repositioning chart which showed they were being supported to move in bed.
- Audits that formed part of the governance of the home had not been completed. Falls and accidents had not been audited since August 2021. This meant trends, and the opportunities to mitigate them, may have been missed.
- The manager was not supported to prioritise risk management tasks. The importance of risk management did not appear to be fully appreciated. For example, we raised concerns regarding bedrails and a person who was a high falls risk immediately after the first day of inspection. Action was not taken until till after the second day of the inspection.

There was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There a staffing structure which gave clear lines of accountability and responsibility. This was displayed on

the wall.
● One member of night staff commented, "It's all very well organised. You know exactly what you have to do."
● The manager and provider were responsive and told us they would develop a service improvement plan and enhance provider oversight. We have not been able to review the implementation or sustainability of these changes.
● Following the inspection the provider told us they had been and were in the process "of checking every aspect of care and the running of the home."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There were a variety of means by which staff could share their views such as: meetings, supervisions, a suggestion box and the contact details for owners. However, we received feedback from two staff that indicated that they did not always feel heard. We asked the manager about this and they told us they would seek to ensure all staff felt able to share their views equitably.
● Staff appeared happy in their jobs which led to a happy atmosphere for people. One person commented that the changes in manager did not impact on them and they could speak to any member of the team if they had a concern.
● People lived in a home where there was an ethos of providing personalised care. Staff knew people well and we saw they responded to their individual needs. Staff spoke about people with care. This ethos of personalised care led to positive outcomes for people. One relative described how their loved one had told them their fears before moving in had been unfounded saying, "This is everything I didn't think a care home would be."
● Relatives were positive about the home. We received comments such as: "The (person) is being very well cared for in our opinion … The home always keeps us well informed of any concerns or changes of circumstances as needed" and "I have been impressed by the kindness and quality of care provided to my mother. … the staff have developed a good relationship with my mother…. For the first time in over six years I feel my mother is safe and being well looked after."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●Where mistakes were made, the acting manager was transparent and acknowledged failings and omissions. They sought to make improvements and reduce the risk of repeated mistakes.
● The provider had a policy in place to support the duty of candour.

Working in partnership with others
● The staff worked in partnership with other professionals to ensure people's needs were met. This included making referrals to professionals to meet specific needs.
● A professional told us that they were able to communicate effectively with the senior team and staff in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment. The risks people faced were not always managed effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance People were not always protected from unsafe care by governance. Records were not accurate