Fairfield Healthcare Limited

Fairfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Fairfield Nursing Home is a residential care home providing personal and nursing care to up to 30 people. The home is a detached property set in its own grounds in a quiet residential area. The service provides support to people in need of nursing support, respite care, end of life care and general assistance with everyday living for people with dementia. At the time of our inspection there were 25 people using the service.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Medicines were not managed safely and the monitoring information for people living in the home was not always completed fully. Risks in relation to people's care had not been properly assessed.
People's dietary needs were identified, however there was no adequate system in place to ensure catering staff had accurate information about people's dietary needs or risks.

The systems in place to monitor the quality and safety of the service were not always used effectively to identify and mitigate risks including allegations of abuse.
Information regarding some agency staff not always available and the information provided to agency staff for the safe care of people was not always up to date.

There were a range of audits completed by the provider and manager, however they were not always effective in identifying and bringing about improvements.

Permanent staff were recruited appropriately and they received training and support for their role. There were enough staff on duty on the day of inspection to meet people's needs.

Equipment had been serviced and maintained and accidents and incidents were recorded and reviewed in order to minimise the risk of reoccurrence. The environment seemed clean and welcoming however it had been recognised by the provider that refurbishment was needed.

Complaints were managed appropriately, and referrals were made to other professionals when people living in the home were in need.

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 01 November 2017.)

Why we inspected
The inspection was prompted in part due to concerns received about the use of medicines, recruitment, and governance of the service. A decision was made for us to inspect and examine those risks.

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.

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the need for consent, fit and proper persons, medicines management, risk management and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Fairfield Nursing 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 Health and Social Care Act 2008.

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
This inspection was carried out b two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Fairfield Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. [Care home name] is a care home [with/without] nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been appointed but had not yet taken up post.

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. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people living in the home, four relatives, five members of staff, the deputy manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at five files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● Records relating to the amount, administration and storage of some of the medicines was not always clear, accurate or safe. Records relating to prescribed creams did not always show these medicines were administered consistently.

● People's end of life medication was not always checked appropriately to ensure it was the correct dose. Management of, and staff practice in respect of end of life medicines was unclear.

● Safe procedures were not in place to administer medication designed to thicken people's drinks to prevent them from choking. During the inspection, we saw that one person's drink had not been thickened to a safe consistency for them to drink and had to intervene. Records in relation to the administration of this medicine were also not properly maintained to ensure they were given correctly.

● Some people who were prescribed 'as and when required' medications such as painkillers or anxiety medication did not have suitable medication plans in place to advise staff when and how to administer these medicines. This meant there was a risk that these medicines would not be given appropriately.

● Where people did have 'as and when required' medicine plans in place, these were not always update and corresponded with the person's current medication requirements.

The provider failed to manage medicines safely so people were placed at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Nursing staff lacked adequate information on people's medical needs and the care they required in order to care for them safely. There was also little evidence people's medical and clinical needs were monitored appropriately. For example, one person's care plan advised staff to monitor their vital signs monthly, and one person lived with a breathing condition, for which they had recently been hospitalised for. There was little evidence either person's health was clinically monitored to identify early signs of a decline in their health.

● Care staff lacked access to sufficient information on people' s day to day care and support needs. This placed them at significant risk of not receiving the right care and support to meet their needs or wishes.

● Information about people's needs and risks was not always consistent and was sometimes contradictory. For example, one person's care plan gave conflicting advice about their dietary requirements, which placed them at risk of receiving an unsuitable diet.

● A risk assessment had not been completed for people with swallowing difficulties to identify the level of risk this posed to their health and safety and it was to be managed. In addition, a risk assessment had not

been completed for people unable to communicate when they are in pain. This was concerning as a significant number of people who lived in the home, lived with dementia and moderate levels of pain and were unable to communicate.
● People who were at risk of developing pressure wounds, had an air flow mattress in place to help mitigate the risk of skin breakdown. Some people's mattresses were not set correctly in accordance with their weight, which increased the risk of the mattresses being ineffective. This was actioned following the inspection however, this issue was identified by inspectors not the manager or provider.
● There is a lack of confidence in some of the dependency ratings for people and staffing levels, for example one person's emergency evacuation plan indicated that they needed six staff to help evacuate them from the building. The nominated individual agreed that this was incorrect and this was reviewed.
● People were not always protected against the risk of abuse. Records for one person showed they had sustained an unexplained injury, however this incident was not reported in line with safeguarding procedures. Managers and staff told us they had no knowledge of the persons injury.

The provider had not ensured risks in relation to people's care were properly managed to prevent avoidable harm. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Regular health and safety checks of the environment had been completed. Service agreements and safety certificates were all in date.

Staffing and recruitment
● During the inspection there appeared to be an appropriate number of staff on duty.
● The staffing rota held names of agency staff, however personel files for those staff did not include information to verify their fitness and suitability to work at the home. For example, evidence of their identity and induction training.
● We identified that over a two week period six staff had worked in the home with no information held about their fitness and suitability.
Following the inspection, the provider sent evidence that this had been actioned and a new system had been put into place however, this issue was identified by inspectors not the manager or provider.

The provider had not ensured staff providing care had the appropriate qualifications, competence, skills and experience which are necessary for the work to be performed by them. This is a breach of Regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment procedures were followed for all other staff including a check on their criminal background.
● Staff recruited through international pathways had all the appropriate immigration checks in place.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes

● The provider was facilitating safe visits for people living in the home in accordance with the current guidance.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant 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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- There was a register in place to monitor whether authorised DoLS in place for people remained appropriate. However, some DoLS authorisations dated back to 2020 without any evidence of a review taking place. There was a risk people's circumstances had changed but not identified. This has since been addressed however it was identified by inspectors not the manager or provider.
- Care records which stated a family member held 'power of attorney' did not always have this information to support this. Additionally, those that were in place were not always correct. For example, one family member held power of attorney for Finance and Property but was signing permission's for their relatives care and welfare.
- Some people had bed rails fitted to their bed. Bed rails are used to reduce the risk of people accidentally falling, or slipping, out of bed. Formal consent for the use of bedrails is required in line with the MCA as they are considered a form or restraint. Despite this, there was no evidence that people's capacity to consent to the use of bed rails had been sought.
- Some people's care plans made suggestions they may lack capacity to make decisions about their care based solely on an impairment to their brain. Throughout the persons care plan these statements were repeated without any further clarification or evidence a full assessment to determine their capacity had been made.

The provider failed to ensure appropriate consent was sought. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People's needs, risks and choices were not always assessed in a timely manner on admission to the home. Therefore staff lacked critical information about how to safely and effectively meet those people's needs. For example, one person who was admitted to the home on 12 September 2022. Due to the number of agency staff used by the home this placed people at risk of avoidable harm.

● People had access to healthcare services when they needed it. However, where professional advice had been given, this had not always been followed up appropriately. For example, staff had failed to follow guidance from a visiting professional who advised staff to monitor the effectiveness of one person's oral pain relief for a five day period.

Staff support: induction, training, skills and experience

● Training deemed mandatory by the provider had been attended by staff. However, there was mixed feedback from people we spoke with in regards to some staff and their understanding of their roles.

● We saw records confirming staff received supervision and support, and staff told us they were appropriately supported.

Supporting people to eat and drink enough to maintain a balanced diet

●There was nutritional information in people's files however, there was no adequate system in place to ensure catering staff had accurate information on people's dietary needs or risks.

● Some people's dietary requirements were was not clear or up to date. For example, one person had a food allergy recorded in their care plan and another person's care plan stated their food was to be cut up, however catering staff were unaware of this information.

● The people we spoke with told us the food was considered to be good. Several family members' had seen the dining experience and said that it was pleasant, and that the food looked very nice. There are several choices of main course and pudding.

● Comments we received included, "The cook does some amazing food, [person] does eat well" and "The food always looks really lovely and the dining experience is very good. Over the last six months [persons] appetite has come back, [person] is eating her meals now. She remarks that the food is nice.

Adapting service, design, decoration to meet people's

● The environment was equipped with aids and adaptations to meet people's needs.

● It had been recognised by the provider that parts of the building was in need of repair and some refurbishment. This was planned for the near future.

● People were encouraged to personalise their rooms with pictures and personal furniture when they moved in.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Records required for people and the running of the service were not properly maintained, accurate and kept up to date.
- There was a lack of evidence to show the manager or provider had reviewed people's care to ensure they received the right care with good outcomes.
- Appropriate investigations did not take place because the provider, managers and staff failed to recognise and act appropriately to allegations of abuse.
- During the inspection, the area manager and deputy manager failed to demonstrate that they understood the service, or the quality of care being provided to people.
- There was a lack of provider and management oversight of the service to ensure regulatory requirements were met and risks to people's health, safety and welfare were mitigated.

The governance arrangements in place were not robust and records were not always adequately maintained. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Continuous learning and improving care

- The provider had reported notifiable events where required to the CQC and maintained records of actions which had been taken. This was to help ensure changes made were effective.
- The nominated individual and deputy manager were open and transparent and discussed in depth with inspectors the issues they had identified with the service, and how they were addressing immediate concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Systems were in place to gather the views of people living at the home and staff. People and their families told us, "There are questionnaires and three resident's meetings, I have been unable to go to them. The minutes were about social events, nothing about care etc", "My sister goes to the residents and staff meeting. Things are followed up and action is taken" and "We have done questionnaires and given feedback that way, I can't think if anything we said which needed rectifying."

● We asked if people knew who the managers were and who they could approach if there were any concerns. People gave mixed feedback including, "Six months ago everything was very good, but it has now changed for the worse", "In certain places it is well run, but the staff are not always quick enough but that is because they are short of staff. No I don't know who the manager is. If I was unhappy about anything I would tell my son" and "I think it used to be well managed, but the standards seem to have gone down now, it is the managers overall responsibility. I know who is, she is very nice and she is very good, she is approachable."
● Staff meetings and supervision took place regularly to share information and learning with the staff team.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure appropriate consent was sought.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements in place were not robust and record keeping was not always adequately maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured staff providing care had the appropriate qualifications, competence, skills and experience which are necessary for the work to be performed by them.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to manage medicines safely and had not ensured risks in relation to people's care were properly managed, so people were placed at risk of harm.

The enforcement action we took:

Warning notice issued