Fairlie Healthcare Limited

Fairlie House

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

This unannounced inspection took place on the 25 and 28 September 2018. At the last inspection on 12 February 2016 the home was rated Good in each key question and Good overall. At this inspection we found significant improvements and examples of very good and excellent practice. We judged it to now be Outstanding in two key questions and overall.

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

Fairlie House accommodates 45 people in one adapted building across three separate floors, each of which have adapted facilities.. There were 43 people using the service at the time of the inspection. The nursing home cares for people with complex neurological needs, sensory impairments and physical disabilities as a result of brain injury or neurological conditions.

There was a registered manager in place. They had been registered with the Commission as the registered manager for the home since December 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

We found there were very good aspects to the systems to monitor safety at the home. Robust fire safety processes were in place and there were effective premises and equipment checks. Risks to people from their individual health needs were carefully assessed, monitored and comprehensive guidance provided to staff to reduce risk. However, one care record did not clearly track the monitoring of skin integrity risk. We saw this was addressed immediately at the inspection.

People were protected from the risk of abuse or neglect. Staff were fully aware of the action they needed to take to ensure people's safety and well-being. Accidents and incidents were recorded, monitored and acted on appropriately with actions to minimise reoccurrence. There were excellent systems for identifying and sharing learning from adverse events.

There were systems in place to ensure people were protected from the risk of infection and the home was clean and well maintained. There were enough suitably trained staff to meet people's needs and safe staff recruitment practices were in place. Medicines were managed, administered and stored safely. Staff were trained to manage medicines and their competences assessed.

The home was distinctly effective, which improved outcomes for people. There was a dedicated comprehensive system of appropriate training, competency assessment and support for staff to provide the right knowledge and competence for them to carry out their roles effectively and safely. This was constantly

evaluated for improvements.

People's clinical physical, mental, social and therapeutic needs were holistically assessed using best practice and current guidance, before they moved to the home to ensure staff and the home environment could meet their needs safely.

People's nutritional needs were supported in a safe and highly personalised way.

People complex health needs were supported through positive working relationships amongst the home's staff and with external health professionals.

The home fulfilled its responsibilities under the Mental Capacity Act 2005 (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves.

The home environment was well maintained and adapted to meet people's needs.

People and their relatives told us the home was very caring and some relatives were exceptionally complimentary about the care at the home. We observed staff to know the people they supported well and to be respectful, caring and considerate.

There was a strong values framework that underpinned the provider's approach to person centred care. Staff had received training on this and support to put this into practice.

People's privacy and dignity was very much respected and maintained and staff supported people to develop and maintain their independence. People were proactively supported and encouraged to maintain relationships with people that were important to them.

People's communication needs were considered and where possible, they were able to express their views, and be involved in decisions about their day to day care. Assistive technology was promoted to improve people's ability to communicate.

The service was exceptionally responsive. People had individually developed person centred care and therapy plans that reflected their needs. The home was proactive in supporting equality and respecting diversity.

People were encouraged to choose manageable goals which improved their lives. The staff team worked collaboratively in partnership with a range of organisations to improve people's life experience. People's quality of life was enhanced by assistive technology, and the stimulation and activities provided in conjunction with the therapy team.

Most people and their relatives told us they had not needed to make a complaint and any issues were promptly dealt with. There was an effective complaints process in place.

The home had recently been recognised for its outstanding end of life care.

Aspects of the home were extremely well led. People, their relatives, staff and health professionals gave us very positive feedback about the way the home was run. The home's values framework was familiar to staff and underpinned its governance and quality control.

The home supported training and development in the community to improve care.

People were encouraged to give their views about the service and these were listened to.

The home had developed a comprehensive quality assurance framework which it was embedding at the time of the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe.

There were very robust processes to manage risks in relation to premises and equipment. Risks in relation to people's clinical needs were managed positively in the least restrictive way but safely, to protect people from possible harm. However, we found some issues in relation to one person's records. These were addressed during the inspection.

People were protected from the risk of abuse or neglect. Staff were fully aware of the action they needed to take to ensure people's safety and well-being.

Accidents and incidents were recorded, monitored and acted on appropriately. There were very good systems for identifying and sharing learning from adverse events.

Infection control practice was effective. There were systems in place to ensure people were protected from the risk of infection and the home was clean and well maintained.

There were enough suitably trained staff to meet people's needs and safe staff recruitment practices were in place.

Medicines were managed, administered and stored safely. Staff were trained to manage medicines and had their competencies assessed.

Is the service effective?

Outstanding ☆

The service was distinctively effective

There was a comprehensive system of appropriate training competency assessment and support for staff to provide the right knowledge and competence for them to carry out their roles effectively.

People's clinical physical, mental social and therapeutic needs were holistically assessed using best practice and current

guidance, before they moved to the home to ensure staff and the home environment could meet their needs safely.

People's nutritional needs were supported in a safe and very personalised way.

People complex health needs were supported through strong relationships amongst the home's staff and with external health professionals.

The home fulfilled its responsibilities under the Mental Capacity Act 2005 (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves.

The home environment was well maintained and adapted to meet people's needs.

Is the service caring?

Good

The home was caring.

People and their relatives told us the home was caring. Some relatives were exceptionally complimentary about the care at the home. We observed staff to be gentle, caring and considerate.

There was a strong values framework that underpinned the provider's approach to person centred care. Staff had received training on this and support to maintain this in practice.

People and their relatives where appropriate, were involved in their care. People's communication needs were considered and where possible they could express their views, and be involved in decisions about their day to day care.

People's privacy and dignity was respected and maintained and staff supported people to develop and maintain their independence.

People were proactively supported and encouraged to maintain relationships with people that were important to them.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive. People had individually developed person centred care and therapy plans that reflected their needs. The home was proactive in supporting equality and respecting diversity.

People were encouraged to choose manageable goals which improved their lives. The staff team worked collaboratively in partnership with a range of organisations to improve people's life experience.

People's quality of life was enhanced by the stimulation and activities provided in conjunction with the therapy team.

Most people and their relatives told us they had not needed to make a complaint and any issues were promptly dealt with. There was an effective complaints process in place.

The home had recently been recognised for its outstanding end of life care.

Is the service well-led?

Good

Aspects of the home were extremely well led. People, their relatives, staff and health professionals gave us very positive feedback about the way the home was managed.

The home had a values framework that was familiar to staff and underpinned it's work with an emphasis on learning and making improvements.

The home supported training and development in the community to improve care.

People were encouraged to give their views about the service and these were listened to.

The home had developed a comprehensive quality assurance framework which it was embedding at the time of the inspection.

Fairlie House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a planned inspection based on the rating at the last inspection.

Before the inspection we reviewed the information, we held about the service to inform our planning. This included notifications we had been sent. A notification is information about important events that the provider is required to send us by law. We also used 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. We also contacted commissioners of the service and health care professionals to seek their views and help inform our inspection planning.

This unannounced inspection took place on 25 and 28 September 2018. The inspection team consisted of two inspectors, a specialist adviser and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day a single inspector returned to complete the inspection.

During the inspection we spoke with six people living at the home and six relatives to understand their views about the care and treatment offered. Some people were unable to express their views and we observed the care provided and tracked that the care given was reflected in people's care plans. We observed the care and support at meal times, spent time around the home, observing in the communal areas and attended a multi-disciplinary meeting and a sensory session. We spoke with two visiting health and social care professionals to understand their experience of working with the service.

We also spoke with the maintenance team, the chef, the therapy team leader, the activities team, administrative staff, the dignity champion, four members of care staff, two senior carers and two clinical matrons, the registered manger, operations director, director of clinical governance, nursing director and deputy manager.

We looked at ten care plans, eleven staff training and recruitment files and records related to the management of the service such as maintenance and equipment checks, accident and incident reports, assessment documents, meeting minutes and audits.

Following the inspection, we received written feedback from one person living at the home and two relatives.

Good

Is the service safe?

Our findings

The home continued to take an active role in relation to keeping people safe from possible risks and we found some very good practice. However, we found monitoring records in relation to one person's pressure area management were not always clear or fully maintained. There was some confusion in relation to the frequency of their repositioning needs within the care plan. This had not impacted on their care as we could identify that the wound had improved. We pointed the records issue out to the registered manager and matron who addressed this.

Otherwise risks to people in relation to their health needs were comprehensively assessed and monitored and detailed guidance provided to staff to reduce the likelihood of risks occurring. Clinical risk assessments were in place, including use of the national clinical guideline NICE National Early Warning Score (NEWS). This guideline has been proven to assist in how to recognise and respond to patients whose condition is deteriorating.

Risk assessments we looked at across a range of health and medical needs such as breathing, falls and choking were thorough and up to date. There was detailed information about the possible risks from moving and positioning people and detailed guidance was provided by the physiotherapy team to enable people to be safely supported and positioned. This was supported through visual guides and photographs for staff who find this more helpful. Additional clinical guidance was also included in people's care plans in relation to specific health risks such as epilepsy or diabetes.

Positive risk taking was considered and we saw how this had been successfully and safely used in collaboration with speech and language professionals to enable one person to enjoy small amounts of food and drink where they had previously been nil by mouth.

The registered manager told us there had been no home acquired pressure areas and we saw risks to people's skin integrity were well monitored and advice from health professionals in relation to frequency of positioning or sitting tolerance was evidenced.

There was a robust approach with fire safety and the monitoring of the safety of the premises and equipment. A fire risk assessment was carried out annually to check for any new risks. Minor actions identified had been acted on promptly. Fire equipment was checked and serviced routinely in line with requirements. All staff took part in fire safety training and monthly fire drills were carried out to ensure all staff at the home understood the fire safety procedure. The operations manager showed us the training and drill practice procedure which was comprehensive. Where fire drills had identified a delay with staff response we saw they were sent on additional training to ensure staff knew how to keep people and themselves safe in an emergency. Fire wardens had fire supervision support to ensure they understood their roles. People had emergency evacuation plans to assist staff and the emergency services with their safe evacuation if required. These were held securely but were readily accessible as well as in their care plans.

The home had an extensive servicing and maintenance arrangement for complex medical equipment with a

nearby hospital. Spare breathing equipment was available in an emergency and the home had a backup power supply and power packs. Other medical equipment and lifting equipment was checked and calibrated in line with requirements. Staff had first aid training and knew how to respond in a medical emergency.

The home had a maintenance team who undertook a range of checks on premises and some equipment within the home, as well as arranging external servicing in line with legal requirements and best practice. This included a legionella risk assessment and legionella testing, gas and electrical safety checks, checks were completed on window restrictors and water temperatures. Oxygen was safely stored and managed. Other equipment such as wheelchairs, bedrails and the call bell system were checked routinely. Any maintenance issues that arose were managed promptly.

People and their relatives told us they felt safe at the home and free from discrimination. One person remarked, "Yes I am safe, I would have left if I wasn't." A relative said, "I feel very privileged what [my family member] has. I would be the first to remove them if I wasn't."

Staff we spoke with understood their responsibilities under safeguarding and whistleblowing and they received regular safeguarding training. The registered manager was aware of their responsibilities and had raised incidents as safeguarding alerts appropriately and worked in partnership with the local authority. At the time of the inspection there were no safeguarding concerns in relation to the care provided at the home. The home provided a safety information booklet for visitors which covered the provided information on aspects of safety such as fire safety, infection control and safeguarding.

There were outstanding elements in the way the home management team and provider promoted an open learning culture in relation to any safety concerns raised and shared any learning about the incidents across the home. Safety was very much viewed as everyone's business. There was a robust reporting framework for any accidents or incidents or adverse events. Depending on the level of seriousness there was a detailed investigation or root cause analysis of the event and the learning was openly shared to promote improvements. Learning from these incidents and accidents was shared across both the provider's homes and displayed for people at the home, staff and visitors to be made aware of. The home had also reviewed its fire safety systems in the light of recent national disasters to understand how they might improve fire safety at the home.

People and their relatives told us they received their medicines when they should. A relative said, "Yes, everything comes on time and smoothly." Our observations and review of records showed that medicines continued to be safely stored, administered and managed. Controlled drugs were safely stored, administered and recorded in line with legal requirements. The home was committed to ensure that medicines were administered by suitably qualified and experienced nurses. Training and a detailed competency assessment was completed before staff could administer medicines. There were detailed policies and guidance across the range of medicines in use for staff to refer to, for example including the use of specialist feeding equipment and oxygen therapy.

Medicine errors were investigated by a senior staff member, a staff reflection, supervision, training was completed following any error and an investigation or safeguarding alert would be raised if appropriate. The provider's Director of Quality and Clinical Governance discussed how a recent pattern with a small number of recording errors had been identified, resolved and learning was shared.

Safe recruitment practices continued to operate to reduce the risk of employing unsuitable staff. The full range of necessary recruitment checks and professional registration, where relevant, were completed.

People and their relatives told us they thought there were enough staff and call bells were answered promptly where these were in use. One person said, "Yes. They are always on hand. I can always call easily for one of the nurses on duty." Another person commented, "Yes, there are always lots of staff about." A third person told us, "Night staff always make sure I have the call bell in my hand." Our observations confirmed this as we did not observe people waiting for long periods for support throughout the day. There was a dependency tool in use that was used to assess safe staffing levels and staff skill levels were also considered. We saw staffing levels could be flexed to allow for activities such as outings.

Many of the people using the service required one to one staffing at all times, because of their high risk complex care needs and for the oversight of equipment related to their care. There were dedicated staff in place on each shift to provide this level of support and other staff supported them to take their breaks. This was clearly tracked to verify that one to one care was maintained at all times. People confirmed that support was in place. One person said, "Oh yes there is always someone with me."

The provider employed a therapeutic team of health professionals as part of the multi-disciplinary team to ensure that the right expertise was available to meet people's needs.

Relatives and professionals told us the home was clean when they visited. A relative remarked, "When you walk in it doesn't feel like a care home, it's always clean and tidy." Another relative remarked that their family member, "Was always getting chest infections in hospital, but since they have been here, not one."

Throughout the course of our inspection we observed the home was clean and free from odours. Hand washing reminders were displayed in communal bathrooms and toilets and hand sanitizer was available and was being used by staff throughout the service to promote good infection control standards.

Staff including housekeeping staff were aware of good practice in relation to infection control.
They told us that personal protective equipment such as gloves and aprons and cleaning equipment was made readily available to them and care staff when they needed it. Training records confirmed that staff had completed infection prevention and control training and food hygiene. A flu vaccination programme for all people at the home and staff was also provided to reduce risks of spreading infection.

The service was awarded a rating of five by the food standards agency in February 2018, which is the highest possible rating. The food standards agency is responsible for protecting people's health in relation to food. We saw that there were systems in place to monitor infection control procedures within the service and audits and checks were conducted on a regular basis in areas such as, hand hygiene, waste management, catheter care, kitchen, laundry and linen, housekeeping and daily cleaning schedules for all rooms.

Outstanding ☆

Is the service effective?

Our findings

There were outstanding aspects to the care provided in the way the home worked within and across organisations to deliver effective care to improve outcomes for people who might otherwise have remained in hospital. The provider employed a multi-disciplinary team (MDT) that provided support care and treatment to people. We observed an MDT meeting and found staff communicated actively across departments and considered the whole person's needs together, (their clinical, social and emotional needs) and with sensitivity and compassion. The registered manager had detailed knowledge of each person at the home and consideration was given to the situation of family members as well as people's moods or needs for stimulation.

People had patient passports and tracheostomy licences which staff had developed to ensure unfamiliar medical staff had details of people's complex care needs during a hospital visit or in an emergency. Emergency plans were in place for people likely to need hospital readmission and where possible people were treated within the home as their preferred place of care with support from health professionals.

People's eating and drinking requirements were met in a highly personalised way. Some people at the home needed specialised feeding regimes which were carefully monitored and food was introduced only under external specialist health professional advice to reduce risk. The chef worked collaboratively with the nursing team and health professionals to safely reintroduce food tastes for people where this appropriate. For one person where this had been successfully introduced they had their own pictorial cards of foods they could safely eat and chose from those.

There was a written menu and the chef had also created a book of menus to encourage choice for people to select from. The chef worked with nursing staff and health professionals to understand people's full dietary requirements and remain up to date with any changes made. The information was readily accessible for kitchen and nursing or care staff and we tracked three people's dietary needs and saw that they received food and drinks in line with these requirements and these were also consistent with their care plans.

People and their relatives told us their dietary preferences and cultural needs were respected and catered for. A relative told us, "My [family member] was peg fed, but when he could eat the chef would make him anything he wanted to eat." The chef told us they spent time with another chef learning a range of culturally specific menus to meet the needs of people at the home. The chef knew people well and spent time talking with people and family members to better understand and cater for people's preferences.

People's fluid and food intake was monitored to identify any changes in appetite and ensure their needs were met. We observed the lunch time experience and saw that where people needed support and encouragement this was done in a calm friendly and supportive way, at their pace and in line with their care plan. Where appropriate people were provided with specialist cutlery to enhance their independence.

People, their relatives and health professionals told us staff were competent, knowledgeable and skilled; and carried out their roles effectively. One person said, "They are very good. They do know what they are

doing. I am in safe hands." Another person remarked, "Yes the way they talk to me tells me that they have been trained." A relative commented, "They are very competent." A health professional told us, "The staff seem competent and knowledgeable – more so than in other places where I have worked."

Staff were complimentary about the training, supervision and development support available and said that it supported them meet the needs of people using the service. One member of staff said, "The training we have is very good and very specific to the people we support." Another staff member told us, "The training we get is very thorough. It is intensive but so helpful and needed with the complex needs of some people. I feel I am given plenty of support to do my job well." A third staff member commented, "There is loads of support and supervision here. It is a really good place to work."

We found the training and support offered was comprehensive and distinctive. The provider and management team commitment to staff learning and development was evident from their training programme. Staff development was encouraged through employer funded professional development. All new staff were inducted into the service in line with the Care Certificate. The standard set for all staff new to health and social care. The induction also included a two week 'buddy' period in which they shadowed an experienced member of staff who ensured the staff member had a full orientation in the service and supported them in the early stages of their employment. A new staff member commented, "The induction was so good, I knew everyone on the floor very well before I started." This meant there was a framework for new staff to develop confidence and skills and that people were continually supported by staff who were confident they had the appropriate knowledge, skills and experience to meet their needs.

Training was delivered by dedicated and competent clinical trainers who regularly updated their skills. Other staff also received training to enable them to train and observed others competently. Staff were able to attend hospitals to receive training in relation to particularly complex medical needs. The training provided to staff was specific to the specialist skills required to meet the complex needs of the people they cared for. Staff completed relevant skills training and competency assessments identified as particular to their roles. Detailed observed competency assessments in relation to the use of specialist equipment and people's complex care needs were carried out; for example, in relation to tracheostomy care and pressure ulcer prevention. These were reviewed regularly to ensure all staff remained competent to meet people's needs. Refresher competency assessment and training was provided to ensure all staff continued to remain competent to deliver care and support to people with complex health needs using specialist equipment. External specialist training was also provided, for example, end of life care training courses were run in conjunction with the local hospice.

Training courses were adapted to suit a range of individual staff learning styles to ensure all staff were able to learn and fully understood their roles. For example, the use of pictorial teaching formats for some areas of work and demonstration/practical teaching. Refresher training or skills updates were provided in small groups during protected learning time, which we saw was factored in for both day and night staff. This enabled staff to embed learning and night staff to receive training at an appropriate time. A simulation lab was also booked for nursing staff to complete a clinical competency assessment. The management team also audited their training to look for improvements.

People's needs were assessed thoroughly in line with evidence based guidance. A health professional told us, "I think Fairlie looks at the holistic needs of people in their care very well." The registered manager told us that because of the complexity of people's needs a detailed pre-admission assessment was completed and this included gathering information from the person concerned where possible, their families and the health professionals that gave them care. The therapeutic team also completed a detailed assessment of people's therapeutic needs.

Assessments were in depth and considered people's medical history, their health and support needs, communication, emotional needs and assistive technology requirements. Staff completing assessments were knowledgeable and demonstrated awareness of current national good clinical practice guidance to ensure they were as effective as they could be at assessing people's needs. A commissioner of the service told us, "We consistently get positive feedback from other professionals' people and families. Through the care and good working relationships with local hospitals and professionals they enable people to live in the community who might otherwise be in hospital."

Health professionals we spoke with at the inspection commented positively on the way the staff at the home worked and communicate with them. One health professional told us, "They work closely with us and provide very good care. It is one of the best of all those I visit." Another health professional stated, "I recommend Fairlie House without hesitation. The home worked closely with the hospital care at home team for some medical needs that would otherwise require a hospital admission.

People's routine health care needs were met. The GP visited twice a week and told us the staff at the home "are very caring and attentive to people's health needs." We saw arrangements were made for people to see other health professionals as required. People were supported by visiting health professionals such as dieticians and speech and language therapists where required to address their nutritional needs. Any recommendations and assessments were recorded and were then transferred into the plan for their care.

People told us staff sought their consent before they provided care. A relative said, "Definitely they do even the new ones." Staff were aware of the importance of obtaining consent and told us they sought consent from people when offering support and respected their wishes. Staff demonstrated knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) including people's right to make informed decisions independently, but, where necessary to act in someone's best interests.

The 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and spoke with service's MCA and DoLS lead. Care records we looked at showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests. For people that did not have relatives involved in their care, the home arranged for an Independent Mental Capacity Advocate (IMCA) to support people and represent their views at important meetings about their care.

We saw that applications had been made to local authorities to deprive people of their liberty for their safety, where this was assessed as necessary for their safety. Where these applications had been authorised, we saw that the appropriate documentation was in place and any conditions of authorisations were appropriately followed by staff.

The premises were suitable to meet people's needs and people's rooms could accommodate the equipment and staff they needed to remain safe. People could personalise and decorate their rooms as they chose. There was a gym and therapy area, a conservatory and garden that people had access to which they

enjoyed. The premises were well maintained and comfortable and there were lifts to allow access to all areas.

Good

Is the service caring?

Our findings

People and their relatives were positive about the care and support they received from staff and some were very complimentary about the care they received. One person said, "I have a wonderful team, wonderful, they really look after me well constantly and importantly have a good sense of humour." Another person said, "Yes without a doubt." A third person said the majority of staff about 95% are kind."

A relative told us, "I can't sing and dance about [staff] enough. Honestly they are fantastic." Another relative said, "This is my second home. It was a really difficult time but the staff and managers made it easier. They are like family." A third relative commented, "The staff give 100% and more." People and their families told us they liked the home-like atmosphere at Fairlie House. A fourth relative remarked, "I wanted [my family member] to come here as it's much more like a home than anywhere else we saw."

Two relatives told us how they and their family members had been supported by the home and staff to attend important events with their family member. They also explained how they had felt reassured by the care provided to their family members at the home. This had enabled them to return to work and go on holiday because they were now confident in the care being provided. A relative said, "The difference they have made to my life and [my family member's] cannot be put to words]. They have helped me to hope again."

The deputy manager told us that the ethos of the home was about living as well as possible. Our observations were that staff spoke to people with warmth, kindness and compassion. We observed staff share a joke with people and support them to become more comfortable. Staff knew people's needs and preferences well. They understood people's body language and gestures. They spoke with people and family members with encouragement and sensitivity. We observed that there was a positive atmosphere among most people living at the home and staff contributed to this in the way they approached and supported people. A relative remarked, "There is no need for favourites here as the staff are all good."

The provider had a values framework which was their foundation for person centred care. This included their core values such as dignity, choice and fulfilment as well as attributes such as empathy and openness. The core values were displayed throughout the home to remind staff and for people and visitors to be aware of. Staff received core values training to support them to understand and put them into practice. Staff told us they understood the core values and tried to put them into practice as much as possible.

People were consulted as actively as possible in decisions about their day to day care. We observed that people were consulted about their personal care and how they wished to spend their time. They were encouraged to be able to choose how they spent time using assistive technology and electronic equipment. One person said, "The tablet is a vital piece of equipment to me. It allows me to have a little independence of the TV." Where appropriate people had access to advocates to support them to express their views.

Where people were unable to communicate through speaking staff told us how they could communicate and recognise people's wishes through their body language or gestures. The home used 'assistive

technology' (technology to empower people to become more independent) to ensure that where possible people could communicate with staff, their visitors, families and professionals about their views and wishes. People who used this technology told us staff understood how to communicate with them and this had improved the quality of their lives. A relative said, "They talk to [my family member] and they respect them. They give that love and care as best they can."

People and their families told us they were treated with dignity and respect and we observed this to be the case. One person responded to say, "Yes, my bedroom is my kingdom." Another person commented; "Yes, I have, 'A Do Not Disturb' sign which I place on my door and they leave me alone." A relative said, "They always knock and are very polite and considerate." Staff accompanied people to hospital appointments and outings to provide reassurance to people and their families.

Staff described how they provided personal care and ensured they respected people's dignity and privacy by closing doors and covering people. People's preferences in relation to their routine were respected. One staff member told us, " It is really important we think about people's privacy."

The home had a proactive dignity champion who told us they promoted awareness of dignity and respect as values in relation to the 'Dignity do's.' these are statements or pledges promoted by the National Dignity Council in relation to promoting dignity for people in care services. The dignity champion had run a dignity session for people their families and staff to discuss dignity and what it meant to them and these statements were displayed on a 'dignitree' to remind staff of their importance. Further events were planned through the year to keep dignity in people's minds.

Links with families and other important people were encouraged. A relative said, "If my wife can't make it and when [my family member] is doing activities they will put them on Facetime." People's families were supported through family meetings to support them and help them understand the care and treatment provided. People told us that visitors were encouraged. One person said, "My visitors can come when they want; it is not a prison here." A relative remarked, "To me personally it feels like a family place, not a home. It feels like a person's home. You feel very comfortable when you enter." "Families were invited to share meals at the home. People's birthdays were celebrated with their families with food and drinks and their rooms decorated. Arrangements had been made for one person's pet to visit them during a period of isolation due to an infection.

People were supported to maintain their independence and links with their community. For example, one person was supported to attend their place of worship to lead a group activity. This involved additional night staff being rostered to meet this need. Younger people could attend a youth group at weekends at a local hospice to socialise with people of a similar age. A group of people had been supported by staff to attend a special evening birthday event at a London hotel earlier in the year.

Outstanding ☆

Is the service responsive?

Our findings

People received personalised care that was tailored to their unique diverse needs. People's needs were carefully assessed and planned for before they came to Fairlie House to ensure they could be safely met. This could involve staff working alongside hospital staff to fully understand people's care needs. A commissioner of the service told us, "We consistently get positive feedback from other professionals' people and families. Through the care and good working relationships with local hospitals and professionals They enable people to live in the community who might otherwise be in hospital."

People's needs were reassessed when they came to Fairlie House and a comprehensive person-centred plan for their care was drawn up. Where possible this was discussed and developed with people and their families or those who had authority to act for them where appropriate. It was reviewed at regular intervals, to ensure they reflected any changing needs. A relative said, "They are good at involving families." Care plans we looked at addressed all aspects of people's physical, mental, social and personal care needs as well as their personal history and preferences to help staff develop relationships with them. The therapeutic assessment was an integral part of the care plan. All aspects of care delivery were matched to the commissions five key questions.

There was detailed guidance for staff to follow with an explanation provided to people and staff of the reason for the care and support and how the effectiveness could be evaluated and monitored. For example, in relation to pressure care, the frequency of repositioning a person was explained and the rationale provided for the frequency and use of repositioning charts. This helped remind staff, people and families of the importance and reasons for the support provided. Some guidance was illustrated through pictures to aid staff understanding.

People's care plans addressed their disability needs and how meet any needs in relation to their culture, religion and sexuality. People's diverse needs and human rights were supported, encouraged and respected. Care plans reflected individual's preferences, social and cultural diversity and values. Staff demonstrated an excellent understanding of people's diverse needs. Staff had received training on equality and diversity and provided examples of how they had supported people's diverse needs such as same sex partnerships and people's disability needs. A relative remarked on how staff awareness of equality and diversity was shown in the way they worked. "Also, they talk to [family member] like an ordinary person, no funny voices because they are disabled." Where it was their reference people could be supported to attend a local place of worship and a religious service was held weekly at the home, for those who wished to take part. We observed people individually enjoying music from their culture where this was their choice. There were advertisements around the home for people to patriciate in a black history month event.

The registered manager told us, "We make sure that those receiving care are treated with respect that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged."

The home had a policy to ensure it followed the accessible information standard. This standard requires

services to identify, record, share and meet people's information and communication needs. The home utilised a range of assistive technology, for example computer assisted technology and software as part of rehabilitation and to support and enhance people's ability to communicate. People's different communication needs were recorded and known to staff including if they used assistive technology or other forms of communication such as cards or blinking and eye gaze software. We found people were assessed and consulted about considering other forms of communication that might be available.

We saw the therapy team worked in tandem with the activities team to incorporate therapy exercises within activities as a more pleasurable way of aiding rehabilitation. For example, using computer games and tablets to improve dexterity and monitor concentration levels. There was a gym and specialist equipment to support people's therapy. The therapy team supported people with wheelchair driving lessons where this was appropriate.

People were supported to consider achievable goals and aspirations. For example, one person was supported successfully to run a shop within the home. One person said, "All I can say to you is the place is very good. When I came here I could not talk and now I can."

Power packs for specialist equipment were supplied to enable people to go out into the community shopping or to lunch and access other parts of the building; sometimes this was for the first time after years spent in hospital. Where it was possible and met people's choices the staff team worked in collaboration with clinical commissioning groups, health professionals, local authorities and families in productive partnerships to enable people to be safely discharged to live at home. This had included intensive support and training with relatives across the range of their family member's needs, trial visits home with staff and planned discharge meetings coordinated by Fairlie House.

We found the team identified any learning from doing this to incorporate in their future practice. The registered manager explained the importance of the trial visits to instil confidence for people and their families. A family member told us, "I have nothing but praise for Fairlie House and all the staff. They have changed my life and enhanced my family member's."

The home supported people to improve their quality of life where this was possible and funding allowed. For example, one person, a keen and regular football supporter before their illness, told us enthusiastically how they had been supported by staff to attend a match to support their football team and the club provided a space in their VIP box. They were planning to attend again in 2019. Staff told us they had also previously supported someone to attend a music festival.

The activities team supported people's needs for stimulation with a range of planned group sessions some of which were integral and tailored to meet people's individual therapy needs but allowed them to enjoy a social and more entraining experience. The activities team told us they ran sessions that provided for everyone's level of consciousness and each session contained elements personalised to each participant. Their aim was to enhance people's lives as much as possible. They told us they also provided a range of 1 to1 activities in people's rooms.

People who could communicate and their families were complimentary about these sessions. One person said, "I like sensory and the gym and the chats." A relative remarked. "The activity coordinator, always comes with something positive." We saw there were a range of activities including current affairs, time sitting or planting in the garden, music listening, games, podcast session Wii games and sensory sessions. Some people attended a group at a local hospice at the weekends. A visiting library also attended the home.

There were a number of events held at the home for people and families to enjoy, these were advertised in the reception area. A local school visited from time to time. Outings were also organised for those who could participate and where funding allowed; relatives were also invited. One person told us about a trip to Kew Gardens, other trips included the science museum and cinema. The registered manager told us a person who had previously been at Fairlie House and was supported by the home and specialist transport to go and visit the Christmas lights, had donated funds to enable them to run an annual trip to allow people to enjoy this, where appropriate.

Most people and their relatives told us they had not needed to make a complaint and the complaints policy was displayed. One person told us, "It's never been necessary." One relative said, "Only once, they were on to it straight away." Another relative said, "We are always talking to each other. I know as a fact that I can go straight to the top and it would be sorted straight away." We saw complaints were overseen by the registered manager and were managed in line with the home's policy. The home also received many compliments and thank you cards from families.

The core values were embedded in the home's approach to end of life care. The home had just been awarded platinum status, the highest award in the Gold Standards Framework for end of life care in recognition of sustained excellence in end of life care and practice. The assessment report commented on the way the home enhanced people's experiences, the strong leadership in this area, the team work approach and involvement of the chef and housekeeping to ensure all needs were considered. Training and support and reflection opportunities were provided to staff around death and dying, so they were skilled and able to support people and families at this time.

There were systems and processes to support people's and families wishes at this point in their lives. People had detailed plans that covered their care and support needs and wishes and preferences.

An annual memorial celebration was held for people who have died that year and people at the home, families and staff take part to facilitate closure & to celebrate their lives. The home received positive feedback about this event from people and families. A relative of a person who had died told us. "It was their home. They didn't want to die anywhere else, that sums it up. My [family member] came in here seven years ago for palliative care and lived well."

Good

Is the service well-led?

Our findings

People, their relatives and health professionals were complimentary about the management team and told us they were visible and the home was very well led. One person commented, about the registered manager, "Yes, I know her. She runs the whole place. She talks to me from time to time. That woman is very brainy." A relative said, "This [home] is second to none. This has been a long journey for us to find the right home. We have been all over the country within a 100-mile radius of where we live. We visited over 10 places and this is the best place." The annual resident survey showed 95% of people were happy with their access to management.

A recent local authority commissioning report stated, "Fairlie House operates in a way that demonstrated there is an open and transparent culture. Staff are happy working at the home and said they felt valued and appreciated as a member of the team. [The registered manager and deputy] are visible and approachable. This openness enables relatives and staff to seek advice."

We found there were some excellent aspects to the leadership and governance at the home. Although the quality governance framework needed a little longer to embed fully to be comprehensively effective in identifying all issues. For example, we identified a small number of staff appraisals had not been completed and some staff records were difficult to track. One older staff recruitment record had missing character checks. These issues had not been identified by a staff record audit. However, the management team took immediate action and set up a programme to complete the appraisals, reorganise staff records and following the inspection sent us evidence they had addressed the missing documentation. Out of the ten care plans we looked at one care plan contained information about a heath need that was not accurate. This had not impacted on any care but had not been identified in the care plan audit. We found immediate action was taken to address this at the inspection.

One member of staff had not received their annual medicines training in March 2018 and their annual competency assessment which should have been conducted in June 2018. We drew this omission to the attention of the registered manager who took immediate action to ensure the member of staff underwent a competency assessment and they were rebooked to attend medicine training in November 2018. The management team were proactive about addressing any issues. We saw they were in the process of rolling out further competencies for nurses on care planning and medicines which would address the issues in relation to the care plan identified in safe and the number medicines errors.

The quality monitoring systems at the home had changed since the last inspection and there was a strong emphasis on continual improvement. There was a comprehensive quality assurance system being put in place. The Director of Quality & Clinical Governance told us they had started in their role in January 2018 and introduced a new system of clinical governance that was built on by the provider's values framework and the Commissions five key questions. Staff had been given training on the aims and importance of openness to promote effective quality monitoring throughout the home. Staff told us that the management team at the home encouraged them to report any issues in relation to people's safety. One staff member said, "We are all trained in the reporting of any incidents and they stress not to be worried about raising any

concerns." The director explained the importance of all staff buying into the new approach.

They told us the home had plans to make findings from the quality assurance accessible to people and their families on the home's TV channel, in the spirit of openness. The governance framework was overseen by a quarterly quality and clinical governance committee composed of senior members across the staff teams from both the provider's homes. They considered any issues related to quality and safety at both homes.

Staff had attended training on event reporting to remind them of what needed to be reported and how. The staff newsletter on clinical governance showed an overall upward trend in staff reporting events to improve practice. The director showed us the postcard system used to respond to staff reporting any incidents to acknowledge and thank them for this. They told us this was to encourage more open practice, learning and identification of issues at early stages to avoid them developing. Any learning from significant events was shared transparently across both the provider's homes to improve the quality and safety of people's care.

A series of regular daily, weekly, monthly and quarterly audits were carried out across the home by staff at different levels to monitor the quality and safety of the equipment and clinical care provided and check documentation was robustly recorded. These audits covered all aspects of people's care. The home undertook a range of clinical audits in line with best practice for example oxygen audits in line with the guidance from the British Thoracic Society were carried out to monitor and evaluate their use. Antibiotic audits were also completed to look for any patterns, try to reduce infection rates and evaluate the effectiveness of care. Audits were also carried out by the director of quality and clinical governance and other managers including care plan audits, staff records, health and safety, infection control and medicines audits. We saw any learning or action needed from these audits was identified in an action plan. Actions plans we tracked were completed promptly.

The core values framework was central to the way the home was run. Staff told us that the management team displayed these values, such as of openness, respect and compassion and that they led by example. The provider promoted the well-being of staff through for example the provision of free meals when they were on duty. One staff member said, "It's the best place I have ever worked. It's really well organised. The managers here all go that extra mile." Another staff member told us, "The managers here lead by example, people come first. They really try to make excellent care here." Clinical matrons worked alongside staff as role models. The provider operated a values based recruitment process which also included new applicants being introduced to people and staff on the day to observe their engagement

In addition to the core values staff had been supported to sign up to the Social Care Commitment. This is a national initiative and asks employers and employees to commit to "I will..." statements to ensure people using care services are supported by skilled staff who treat them with dignity and respect.

Staff were positive about their roles and told us they loved their jobs. One staff member commented, "I really love coming to work, I love my job. We are a great team and the residents are always put first." Another staff member commented, "This is one of the best places to work and give care." This year's annual staff survey showed 84% of staff said they were enthusiastic about their work. Staff commitment was respected and valued. Meals were provided while working and there was a paid lunch break. There was also a Christmas thank you, staff retention was encouraged through an increase in the hourly rated after five years of employment.

There were a series of regular handovers and staff meetings on each floor and across the home to foster good communication about people's care and support needs and encourage effective team work. Meeting minutes we considered reflected the provider's core values. Staff told us they thought they worked well

together as a team on each floor. One staff member told us, "We support each other. It's important to work together, the people we look after are vulnerable and need us to pull together." In addition, the management team produced regular staff newsletters based on the Commission's five key questions to provide any key information and inform staff about the homes progress in key areas.

People's and their relative's views were sought through surveys and the findings considered by the governance committee and the home produced a 'you said we did 'report of actions identified and taken as a result of survey findings. This was made available for everyone to see. For example, we saw in relation to a suggestion to have a Residents and Family Forum this was in the process of being planned.

The manager worked in partnership with other agencies and was committed to enabling people to lead fulfilled lives. They had initiated and empowered people to contribute to support medical students and nurses training through discussion of their patient experience. This benefitted the person concerned who enjoyed their role and was paid as well as the medical and nursing students learning.

There was a strong focus on learning and development at all levels within the home and externally; with a clear commitment to continuous improvement. Staff participated in the wider provision of training and development in the community through work experience arrangements with a local school and a college and nursing student placements from two universities. Staff were supported to attend mentor training to support this. The provider put on training events on relevant topics for families and professionals in partnership with their other home. Last year, there was a talk delivered by an author of the more recent RCOP guidelines for withdrawal of hydration and nutrition for people with prolonged disorders of consciousness to which staff, families from Fairlie House and external professionals were invited to learn about the guidelines.

The registered manager and the deputy attended local authority network groups to share aspects of the home's practices and experience with registered managers for example, in relation to end of life care. This encouraged and supported other services in improving their provision of care. They had also provided some free training places to another local home on one of their competency training courses. Staff attend a number of brain injury charity functions to support fundraising and the home was involved in fundraising for a children's charity.

At the request of a nursing and care agency the home provided a respiratory and ventilator competency course for several nursing staff to enable them to practice and have a better knowledge and understanding of care provision when caring for residents with tracheostomy and ventilators.