ARMA Care Services Limited

Fairways Residential Home

Inspection report

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New Romney
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 16 February 2018. The inspection was unannounced.

This service is a care home service without nursing. People in care services receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provided residential accommodation and personal care for up to 28 older people with mild to moderate care needs, some of whom were living with short term member loss or cognitive impairment associated with dementia. There were 18 people living in the service when we inspected. The accommodation was provided over two floors, a lift was available to take people between floors.

The service had previously been registered under another provider. ARMA Care Services Limited took over the service and registered as the provider in February 2017. They took over responsibility for people, the staff and the premises from that date. ARMA Care Services Limited had worked to improve the environment, management of medicines, staff training and introduced new policies.

There was a registered manager in post. 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.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The management team understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

Risks assessments continued to be updated and in place for the environment, and for each individual person who received care. Assessments identified people's specific needs, and showed how risks could be minimised. Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and carried personal protective equipment like disposable gloves and apron's.

Staff were deployed in sufficient numbers to meet the needs of the 18 people currently living at Fairways. People's care was delivered safely and staff understood their responsibilities to protect people who were frail from potential abuse. Staff had received training about protecting people from abuse. The management team had access to, understood the safeguarding policies of the local authority, and when needed followed the safeguarding processes.

The premises and equipment in the service was clean, odour free and maintained to protect people from

infection. Safety systems in the service, like fire alarms were serviced by an engineer and tested to maintain people's safety. Risks within the service had been assessed and maintenance issues were reported and dealt with in a planned and timely manner. The fire procedure was in date and was regularly practiced by staff.

The management team involved people in planning their care by assessing their needs prior to and after they moved into the service. People were asked if they were happy with the care they received on a regular basis.

When new staff started working at the service, they received an induction and followed a recognised pathway of basic training to gain the skills required to meet people's needs. Training was on going and included supervision and appraisal.

We observed that staff knew people well, staff displayed a kind and caring attitude and people had been asked about who they were and about their life experiences.

We observed staff were welcoming and friendly. Staff provided friendly compassionate care and support. Staff were trained and understood the importance of respecting people's privacy and dignity.

People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

The activities in the service provided people with opportunities to get involved and participate in learning new skills and building new friendships. Community participation was encouraged and supported.

There were policies and a procedure in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs, community nurses and they accessed opticians, dentists and foot care professionals. People's health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

Incidents and accidents were recorded and checked by the management team to see what steps could be taken to prevent incidents happening again. The risks in the service were assessed and the steps to be taken to minimise them were understood by staff.

The providers had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. There was an up to date procedure covering the actions to be taken in emergency situations.

Recruitment policies were in place. Safe recruitment practices had been followed. The management employed enough staff to meet people's assessed needs. Staffing levels were kept under review as people's needs changed.

Staff were made aware of equality and diversity issues and received training about this. Staff understood the health and challenges associated with ageing people faced and supported people to maintain their health by ensuring people had enough to eat and drink.

The provider had a policy and provided information to people about how to raise concerns or make complaints about their care.

The provider and the management team consistently monitored the quality of the service and made changes to improve the service, taking account of people's needs and views. The registered manager had provided good leadership to staff. The provider and registered manager implemented plans to improve the service.

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 service was safe.

Staff knew what they should do to identify and raise safeguarding concerns.

There were sufficient staff to meet people's needs. Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained.

Is the service effective?

Good

The service was effective.

People were provided with care based on assessments and the development of a care plan about them.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were understood by the provider and staff received training about this.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices

about their care.

People had been involved in planning their care and their views were taken into account.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it and activities were offered to keep people remain active and occupied.

Information about people's needs was updated often and with their involvement, based on assessments and the development of a care plan about them.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The management team continued to implement planned improvements for the service.

People were consistently asked what they thought of the care provided and their feedback had been used to drive the direction of the service.

The provider and registered manager promoted person centred values within the service.

There were clear structures in place to monitor and review the risks that may present themselves as the care was delivered.

Fairways Residential Home

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 inspection took place on 16 February 2018, the inspection was unannounced. The inspection team consisted of one inspector and an expert by experience. The expert-by-experience had an understanding of caring for elderly people.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We observed care in communal areas. We spoke with nine people and five visiting relatives or friends about their experience of the service. We spoke with 11 staff including the registered manager, a senior carer, six care workers and the chef. We looked at records held by the provider and care records held in the service. This included five care plans, daily notes; a range of the providers policies including safeguarding, medicines and the complaints policy; the recruitment and training records of four staff employed; the staff training programme and health, safety and quality audits. We asked the provider to send us further information about equipment servicing, cleaning schedules and dependency assessments. This was received in a timely manner.

The service, under the new provider had been registered with us since 10 February 2017. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

People described and we observed a service that was safe. We saw people were relaxed and smiling when staff spoke with them. All of the people we spoke with told us Fairways was a safe place to live. One person said, "I feel safe because everything is securely locked and you get 24hr care. Even during the night there is someone about. I don't sleep very well and they even make me a cup of tea at 5am." Another person said, "The whole atmosphere and location makes me feel safe, cared for and happy, I feel fortunate to be accepted here." Relatives told us their family members were safe and secure. Another person said, "If you need help you can push a button (Nurse call) and they come as quickly as possible so there are no risks."

A regular visitor said, "My mother was here, it is very safe. I think you can tell by the way the staff show care and consideration when they are helping people move around."

Staff followed the provider's policy about safeguarding people and this was up to date with current practice. Staff were trained and had access to information so they understood how abuse could occur. Staff we spoke with were confident they could challenge any poor practice within the service and report it appropriately. Staff had read and understood the provider's whistleblowing policy. There had been three recorded safeguarding notifications since our last inspection. These had been appropriately reported and investigated under the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse). We noted that the registered manager had used the providers disciplinary policy to suspend a member of staff whilst their conduct was investigated. This recued the risks to people from continued harm. Staff said, "We always look out for any signs of abuse, check that things like bruises have been documented. We can raise issues to the top, if it was a real concern I would go higher." This meant that staff understood their role in protecting people from harm.

Risk within the service were assessed, recorded and regularly reviewed. Actions to reduce risk was understood by staff. For example, before people used the bath the water temperatures were checked by staff to minimise the risk of scalds. These temperatures were recorded. Risks that may affect individual people were assessed and actions taken to mitigate the risks. People had been assessed to see if they were at any risk from falls or not eating and drinking enough. If people were at risk, the steps staff needed to follow to keep people safe were documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety if they had been diagnosed with medical conditions such as Parkinson's or diabetes. In these cases the care people received was overseen by a health care professional such as specialist community nurses and/or GP's. This meant that risks were managed to protect people's health and wellbeing.

Guidance about any action staff needed to take to make sure people were protected from harm were included in the risk assessments. Incidents and accidents records were checked by the registered manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. For example, if people had falls, this was fully recorded so that patterns and frequency could be monitored with actions taken to minimise the risks. Responses to incidents included, the provision

of protective equipment, such as pressure reliving mattresses and/or referrals to specialist nurses services such as for Parkinson's to assist in people's care planning and risks management. Risks management processes included checking equipment was safe. We observed staff ensuring people used walking aids as part of their falls prevention plans. Fully assessing potential risk and taking action to control them reduced the risk when people received care.

The premises were maintained to protect people's safety. A full fire risk assessment had been carried out by a specialist consultant and had been annually reviewed. This had been updated in December 2017 and included loft spaces. Recommended works to improve fire safety had been carried out, for example improving fire doors. The fire systems were serviced by a specialist engineer on a regular basis. Routine maintenance and statutory test supported the effective management of fire safety. Staff received training in how to respond to emergencies and had a good understanding of the fire procedure in place. Fire practice drills had been completed timed and recorded. Where necessary improvements had been made to improve evacuation effectiveness. We observed a member of staff explaining the fire evacuation process to a person who was new to the service. Personal emergency evacuation plans were in place (PEEP's). These PEEP's were written to each person's needs and identified the actions staff needed to take to keep protect people during a fire. Staff told us they understood how to respond in the event of a fire. This meant that the risk of harm from fire was reduced.

There were adaptations to the premises internally and externally to maintain people's safety. For example, ramps to reduce the risk of people falling or tripping. A mobile hoist was available for emergencies if people fell and needed help to get up. Other environmental matters were monitored to protect people's health and wellbeing. For example, equipment was regularly tested, such as hoists, the lift and gas appliances such as boilers, there was also an annual legionella water test. The management team kept records of the premises checks they made so that these areas could be audited. Maintenance records showed that faults were recorded, reported and repaired in a timely manner.

Recent improvements had been made to the flooring in lounge and the garden had been improved to make it accessible. Infection control risks were managed through maintenance and cleaning practices. For example, cleaning was completed following a daily, weekly and monthly schedule. We observed the service to be clean and odour free. Staff were provided with infection control training and we observed staff accessing gloves and aprons. The service had been awarded a five star food hygiene rating in January 2018 by the local authority environmental health officer. Maintaining hygiene, water quality and following good infection control practices reduced the risks of cross infection or exposure to waterborne illness.

Staffing levels were planned to provide skilled and consistent care. Based on a dependency tool, staff were deployed in appropriate numbers within the service to keep people safe and meet the assessed needs of the 18 people currently living at the service. All of the people we spoke with and the staff told us the current staffing levels were consistent and staff told us there were currently enough staff to meet people's needs. In addition to the registered manager, there were three care staff available, including a senior staff member to deliver care between 07.30 and 22:00. Day time staffing numbers were flexible and more staff were available at busy times. For example, more staff were on hand to assist with meal/drinks service. At night there were two wake-in-night staff delivering care, including a senior staff member. We checked the staff rota and saw that the registered manager planned the staffing in advance. Where staff were absent, for example for staff holiday, we could see that other staff worked extra hours and this was marked on the rota. Some shifts not covered in house had been covered by agency staff who had normally worked in the service before. In addition to the care staff, there was a cleaner, cook and maintenance person employed in the service. This meant that levels of care staff hours were consistent.

The provider had policies in place about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. For example the registered manager had a reciprocal evacuation arrangement with another local care home so that people could go to a place of safety if the service needed to be evacuated. This meant that if the service could not be used, people's care could continue safely. The registered manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time.

People were protected from the risk of receiving care from unsuitable staff. The management team followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Staff we spoke with and records confirmed the registered manager followed the recruitment policy. Staff had been through an interview and selection process. Applicants for jobs had completed application forms and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions, or if they were barred from working with people who needed safeguarding. Where issues about staff conduct were raised as safeguarding issues, the registered manager followed the provider's employment law disciplinary processes to reduce risks. Making proper checks on staff reduced the risk to people who may need safeguarding.

People were protected from the risks associated with the management of medicines. This was supported by recorded audits carried out by trained staff and by an external pharmacists. Medicines were only administered by senior staff. One person said, "A senior gives out the pills regularly and watches that you swallow them." Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had capacity to make informed choices about medicines. Staff who administered medicines received regular training, competency checks and yearly training updates. Staff understood how to keep people safe when administering medicines. There was an up to date medicines policy which staff followed. There was a policy about the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. There were systems in place so that medicines were available as prescribed. Medicines were stored securely within a safe, temperature controlled environment. Temperatures were monitored and recorded to protect the effectiveness of the medicines. The system of medicines administration records (MAR) allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by the trained staff on shift. We sampled the MAR records and these had been completed correctly. The senior care staff were responsible for administering medicines and we observed they were doing this safely. Liquid medicines were dated once started and medicines were stored in hygienic conditions. One person was receiving medicines covertly. This process had been agreed and managed within the provider's medicines policy and the Mental Capacity Act 2005 (MCA 2005). For example, the person's health and wellbeing and rights had been protected by a best interest decision involving their close relatives, GP and pharmacists.

Information about people was recorded in care plans which were kept securely in an office and the access was restricted to staff. When staff completed paperwork this was either stored in people's bedrooms or kept in the office to maintain confidentiality. Information about medicines were securely stored in clinical rooms between medicine's rounds. Detailed daily records were kept by staff. Records included personal care given, well-being, activities joined in, concerns to note and food and fluids taken. Many recordings were made throughout the day and night, ensuring communication between staff was good benefitting the care of each person. Staff understood their responsibility to maintain people's confidentiality. Keeping accurate records assisted people to maintain their health and wellbeing.

Good

Is the service effective?

Our findings

People told us that staff met their care needs and we observed this happening. One person told us, "The staff are excellent –they must be well trained and skilful." And, "our girls [staff] are conscientious." Another person said, "The food here is excellent and there are such good portions" Another person said, "If you don't like anything [food] they will change it."

We spoke with another person who said, "They sent for the GP when I had a chest infection he gave me antibiotics. He came a few times."

The registered manager undertook an initial assessment with people before they moved into the service. The assessment checked the care and support needs of each person so the registered manager could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their lifestyle preferences as well as their rights, consent and capacity. The registered manager also assessed people's dependency levels to capture how much staff care was required and how independent people could remain. This was translated into the number of care or social contact hour's people needed. The registered manager involved people and their family members in the assessment process when this was appropriate. This meant that the registered manager could assess how they would meet people's needs at Fairways.

The initial assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. This meat that staff understood the care people needed and how this would be delivered. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. A member of staff said, "We have to read care plans need to know what you are doing." People health and wellbeing was consistently monitored and reviewed in partnership with external health services. The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist. Where people's health was at risk from not drinking enough a plan was in place to monitor and respond to the risk. For example, people had been assessed by a speech and language therapist (SALT) or other professional who advised the staff of the amounts someone should drink in a day. Staff recorded what people drank in their care plan. If people had not drank enough to maintain their health, staff referred them back to the SALT. People at risk of choking were assessed and measures were put into place to minimise the risk through foods that were easily digested or pureed. People's nutritional risk and allergy needs were shared with the chef. Responding to people's health needs protected people's health and wellbeing.

Care plans covered all aspects of people's daily living and care and support needs so that staff could understand people's needs. The areas covered included medicines management, personal care, nutritional needs, communication, social needs, emotional feelings, cultural needs and dignity and independence. The cultural needs plans identified the support required by each person for example, if they needed support to attend the Church. Information such as whether people were able to communicate if they were experiencing pain was detailed. Sometimes people were reluctant to wash or shower and this was addressed in the care

plan for personal care, giving guidance to staff. Most people changed their minds if staff returned a short time later and asked again, or if a different member of staff asked. If people still chose not to wash then this was respected as their decision at that time.

Staff were managing pressure ulcers and wounds effectively. Referrals to the community tissue viability nurses (TVN's) were made promptly. Some people were identified as at risks from pressure ulcers developing and others were at risk from skin tears. These skin/pressure areas were being managed by staff using prescribed creams, body repositioning and air flow mattresses to minimise the risks of serious ulcers developing. At the time of this inspection there were no reported pressure ulcer concerns. This meant that people's skin care was well managed.

People continued to be supported to have enough to eat and drink and were given choices. Staff were aware of people's individual dietary needs and their likes and dislikes. Care records contained information about their food likes and dislikes and there was helpful information on the kitchen notice board about the importance of good nutrition, source and function of essential minerals for both staff and people to refer to. If needed staff supported those people who required assistance with their meal. For example, one person had her food cut into smaller manageable portions by staff. People were offered choices of food and what they ate and drank was recorded to help them maintain their health and wellbeing. We observed lunch being served. Staff were kind and encouraging. The menu was battered Cod/peas/chips or mash. People who did not like fish, had sausages or could choose another alternative. Some people were offered alcohol drinks but most chose fruit juices. Everyone was offered a second helping. The dessert was rice pudding and jam. The Chef told us that fresh fruit and yoghurts were always available and that food was provided all day if required. One person arrived after food service had started and was given their fish diner, but did not eat it. Instead staff made the persons favourite 'jam sandwiches' and gave her an extra cushion to make her 'bottom more comfortable.' Providing the right food and environment to encourage people to eat and drink well reduced the risk of dehydration and health related issues though poor diet.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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.

The service was working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. There had been one recent application made by the registered manager. This included authorisations about a people who lacked capacity and needed to remain in a secure environment. The application had been made within the MCA 2005 principles. Where people could consent to decisions regarding their care this had been documented, and where people lacked capacity, the appropriate best interest processes had been followed. For example, a recorded discussion had been held with people involved in the person's care and/or their advocates. It was then agreed if any imposed restriction remained in the person's best interest. This showed that the registered manager applied the principles of MCA 2005 within the service in a person centred manner which involved people in decisions about meeting their needs effectively.

People's consent and ability to make specific decisions had been assessed and recorded in their care plans. Where people lacked capacity, their relatives or representatives and relevant healthcare professionals were involved to make sure decisions were made in their best interests. Staff had received training in MCA and

DoLS and understood their responsibilities under the act. Applications made to deprive people of their liberty had been properly made and authorised by the appropriate body. These were appropriately notified to CQC.

Staff feedback about the standards of training and supervision was consistently good. The new provider had changed the way training was delivered and a new training planner had started. Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. Staff on shift said, "The new training is much better. It is not just DVD's as now we get a more informative pamphlet, knowledge paper then competency checks." Another staff member said, "The new training is hard, but it gives us the skills we need to carry out our roles." Training was provided in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Staff confirmed to us that they had started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised. Staff were encouraged to complete a Diploma/Qualification and Credit Framework (QCF). To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard.

The registered manager checked how staff were performing through an established programme of regular supervision (one to one meeting) and an annual appraisal of staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff confirmed to us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings.

Good

Is the service caring?

Our findings

People described their care positively. All of the staff we observed were kind and compassionate in the way they responded to requests from people for care and how they tried to meet the needs of everyone. One person said, "They [staff] listen to me and I am able to express an opinion and my ideas are treated with respect." When we asked another person about how caring the staff were they said, "I would give them an A star."

A person visiting their friend said, "Our friend is very happy here."

A speech and language therapist commented. "Fairways has the atmosphere of a family home. Staff have a positive and helpful attitude."

The registered manager and staff had created an enriching and self-stimulating environment, specifically tailored to meet the needs. Staff worked to create a positive atmosphere. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. When people asked if they could sit in the garden they had a conversation with staff about how cold it was. Staff went to get people's coats. Staff got cushions for the garden seats so that people were comfortable and people were given portable nurse call alarms so they could call for help if needed. Less mobile people were gently guided through the door to the garden bench. There was a lot of jollity and good natured conversation with staff. A few times staff broke in to song which was a pleasure to watch as this left people smiling and joining in with songs.

People described staff who were attentive to their needs. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. There were a number of areas people could go to if they wished to sit away from others. People told us staff came quickly when they called them. People were able to see information about the time, date, year and weather forecast in the dining room. This meant that people could orientate themselves with the here and now.

Staff told us they tried to build good relationships with the people they cared for. We observed that staff were polite and cheerful, staff created a lively, jovial atmosphere. We saw staff listening to people, answering questions and taking an interest in what people were saying. When speaking to people staff got down to eye level with the person and used proximity and non-verbal's (good eye contact, caring gestures like a gentle touch, smiles and nods). Staff used people's preferred names when addressing them. The records we reviewed contained detailed information about people's likes and dislikes. Staff were aware of people's preferences when providing care.

We observed that staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the service. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff.

The registered manager had started a key worker system. Each member of staff was key worker for some people. (This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their care.) They took responsibility for ensuring that people for whom they were key worker had sufficient toiletries, clothes and other supplies and liaised with their families if necessary. This enabled people to build relationships and trust with familiar staff.

People had choices in relation to their care. People indicated that, where appropriate, staff encouraged them to do things for themselves and stay independent. Staff closed curtains and bedroom doors before giving personal care to protect people's privacy. People told us that staff were good at respecting their privacy and dignity.

Staff we spoke with understood their responsibilities for preserving people's independence, privacy and dignity and could describe the steps they would take to do this. Access to information about people was restricted to staff.

Good

Is the service responsive?

Our findings

We observed staff consistently delivered responsive care. People told us the registered manager and staff were responsive to their needs. People were confident they could raise complaints if they needed to. One person said, "I would resolve any issues with the manager or senior carer."

A relative said, "They are very good at celebrating birthdays with a cake and card .Christmas and Easter were made special."

Staff continued to help people to stay in touch with their family and friends. For example, we observed relatives freely coming into the service to visit their family member throughout the day. Staff maintained an open and welcoming environment and family and friends continued to be encouraged to visit. Relatives said they were kept up to date about care plans and called in or notified if there were any changes. One relative said, "I can discuss mum's health and care with the manager anytime I visit. If they need to make any changes they will do so." Their involvement was recorded in people's care plan files.

Resources were made available to facilitate activities. This promoted an enhanced sense of wellbeing, with staff responding to people's social needs. There was a range of activities available for people from arts and crafts, singing, social evenings and themed events. Since the start of the year there had been church services, alive and active sessions, sing song sessions, movie shows, music sessions, reminiscence sessions, a Valentine's day quiz and 1-1 chats with most people. There were also times when staff took time to sit and talk with people. One person went to do arts and crafts at a local group. There was an established activities program. Another person said, "I love the musicians and sing songs" And, "One man [staff] comes in and takes me for a walk." Activities and events were advertised and written about in newsletters and on posters. By providing meaningful stimulation and occupation, people became more engaged and interested and could continue with their hobbies and interest. Photographs were taken of activities. This was a reminder for people and also gave their visitors topics they could talk about. The planned activities gave people an interest and helped them remain physically or mental more active.

Staff knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs. The staff showed in discussion with us they understood people's dementia and how this impacted on their life.

People continued to receive personalised support which met their specific needs. Each person had an up to date care plan which set out for staff how their needs should be met. Care plans were personalised and contained information about people's likes, dislikes and their preferences for how care and support was provided. Care plans were reviewed annually with people, or sooner if there had been changes to people's needs. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff.

People had not had cause to complain. However, the provider had a comprehensive complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was on display in the service. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively of the staff and management team. One person said, "The new owner [provider] is very good. He comes down to visit every week and comes in to see me. He is a very nice young man." Another person said, "The manager comes in to speak to me. She is very friendly." Another person said, "All the staff work as a team." Another person said, "I think they are a good team, they have all been here a long time and they are very understanding; it's a family."

Some staff told us that they had been employed at Fairways for a number of years and felt that the management respected their views. Staff told us they had seen improvements under the new provider. One member of staff said, "The new owner [provider] has made a few changes like creating an office downstairs. This gives private space as before we kept info in cabinets in dining room." Also, "The pre-packed nomad medicines are gone, we now use packets. This is working better as we have better understanding of what people's medicines are." All of the staff we spoke with told us they enjoyed working at Fairways and felt it was a well led service. Staff also said that they all had a good working relationship with each other, but if they observed a member of staff doing something that they were not entirely happy with, they would have no hesitation in bringing it to their registered manager's attention. A member of staff said, "We have very good communication within the staff team." Teamwork and good communication meant that people received a consistent level of care.

The provider told us, 'We have a policy of honesty and transparency. This means that we are constantly informing the residents and families of our improvement plans, where we have been investing our time and money, and where concerns have been identified that we need to work on. We have been undertaking a process of changing many things, such as care plans and audit forms, in order to allow us to provide better person-centred care.' This was achieved by the provider proactively seeking people's views and taking action to improve their experiences. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. The questionnaires asked people what they thought of the food, their care, the staff, the premises, the management and their daily living experience. Other meetings were advertised and took place for people who used the service and their relatives. For example, changes had been made to update decoration in the home and the provider planned to improve the garden after receiving feedback. Asking people about their views of the service assisted the provider in taking action to improve the quality.

Staff told us that the management team encouraged a culture of openness and transparency. Staff told us that the registered manager had an 'open door' policy which meant that staff could speak to them if they wished to do so and the registered manager worked alongside staff as part of the team. Support was provided to the registered manager and by the provider who visited weekly in order to support the service and the staff. There were systems in place to check the staff training records to make sure staff training was up to date and staff were equipped to carry out their role and responsibilities and any training needed was booked.

We looked at the arrangements in place for quality assurance and governance in all areas. Quality assurance

and governance processes are systems which help providers to assess the safety and quality of their services. We found that the provider had implemented good quality assurance systems and used these principles to critically review the service. They completed audits of all aspects of the service, such as medicines, kitchen, personnel, learning and development for staff. The provider also carried out a series of audits either monthly, quarterly or as and when required to ensure that the service runs smoothly, such as infection control. We found the audits routinely identified areas they could improve upon and the deputy manager produced action plans, which detailed what needed to be done and when action had been taken. For example, changes had been made to improve medicines safety and a new care planning system was being introduced. We saw the registered manager and provider checked people's care plans, risk assessments and daily logs to ensure they were up to date and completed to a good standard. Keeping people's care reviewed meant that their current needs were always met.

The provider had clear values which were promoted by the management team to all staff. The culture of the service was inclusive. Staff we spoke with consistently demonstrated the provider's values to help people regain their confidence and continue to live as independently or with as little support as possible. Staff told us they felt part of the team and were able to contribute to meetings and share ideas for the benefit of the people using the service. The management team met with staff in meetings. They discussed the operational effectiveness of the service and any issues or concerns arising with the service they were providing to people.
Management provided leadership in overseeing the service and provided support and guidance where needed.

The registered manager worked closely with social workers, referral officers, occupational therapists and other health professionals to make sure people received appropriate care. The right support and equipment were secured promptly and helped people continue to live independently, safely or be referred to the most appropriate services for further advice and assistance. For example, profiling beds, wheelchairs or walking aids. The provider holds membership of the Kent Integrated Care Alliance. This gave them the opportunity to network and attend events to keep up with changes and developments in social care.

We reviewed some of the provider's policies and procedures and saw these were updated on a regular basis to ensure they reflected current legislation. For example, they referred to the most up to date Care Act 2014 and recent changes to medicines guidance.

The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. Staff told us policies and procedures were available for them to read and they were expected to read these as part of their training programme. This meant that people experienced open and transparent care that protected them from harm.