Fairfield House Healthcare Limited

Fairfield House Residential Care Home

Inspection report

Fairfield House
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Date of inspection visit:
19 January 2018
22 January 2018

Date of publication:
05 March 2018

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

This inspection took place on 19 January 2018 and was unannounced. The inspection continued on 22 January 2018 and was announced.

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

The care home accommodates up to 36 people across two floors. The service is located in Lyme Regis and is a large detached building with rooms arranged over two floors and a central ground floor lounge and dining area. There is both lift and stairlift access to the first floor. People are able to access secure outside space at the home. There were 28 people living at the home at the time of our inspection.

At our last comprehensive inspection on 27 September and 4 October 2016 we found that people's care and treatment was not always appropriate or met their needs. Care and treatment was not always designed with a view to meeting people's individual needs. The registered persons were not acting in accordance with the Mental Capacity Act (2005) to ensure care and treatment of people was provided with consent. People's nutritional and hydration needs were not always met to ensure food and hydration was adequate, dietary supplements were not consistently given and people were not always provided with the support required to keep them hydrated. Systems were not always in place to ensure concerns were picked up and met through the quality assurance process.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take steps to improve and ensure that they were compliant. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Effective and Well led to at least good. At this inspection we found that improvements had been made.

The service did not have a registered manager in post at the time of inspection. However the manager had applied to CQC and since our inspection they confirmed that they had successfully registered. 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.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of the risks that people faced and understood their role in managing these to ensure people received safe care. Risks around behaviours that could challenge were planned to be recorded in people's care plans where appropriate.

People were supported by enough staff to provide effective, person centred support. Staff were recruited safely with appropriate pre-employment checks and received training and support to ensure that they had the necessary skills and knowledge to meet people's needs.

People received their medicines as prescribed and staff worked with healthcare professionals to ensure that people received joined up, consistent care. Where written guidance around medicines prescribed 'as required' was needed, the manager confirmed that this would be put into place.

People were supported from the spread of infection by staff who understood their role in infection control and used appropriate Personal Protective Equipment (PPE).

People were supported to make choices about all areas of their support and staff understood the principles of mental capacity. Where decisions were needed in people's best interests, these were in place.

People were supported to have enough to eat and drink and there were systems in place to ensure that any concerns around weight loss were monitored. People's preferences for meals were well known and choices were offered if people did not want the meal provided.

People were supported to receive personalised, compassionate end of life care and their wishes and preferences were recorded.

People and those important to them were involved in planning the support they would receive and also regularly asked for their views about the support and any changes to people's needs. Reviews identified where people's needs had changed and reflected changes to the support provided in response to this.

People were supported by staff who respected their individuality and protected their privacy. Staff understood how to advocate and support people to ensure that their views were heard and told us that they would ensure that people's religious or other beliefs were supported and protected. Staff had undertaken training in equality and diversity and understood how to use this learning in practice.

Interactions with people were kind and caring and relatives told us that they had peace of mind that their loved ones were receiving safe, compassionate care.

People were supported to access healthcare professionals when required and the service worked with a number of external agencies to ensure that people received joined up, consistent care.

People were supported to have one to one time with staff in social activities which were meaningful to them. Visitors were welcomed at the home and kept up to date about how their loved ones were.

Staff were confident in their roles and felt supported by the manager. Feedback from people and relatives indicated that the manager was approachable, listened and took actions where necessary.

Quality assurance measures were used to highlight whether any changes to policy, processes or improvements in practice were required. We were given examples where feedback had been used to drive improvements at the home.

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

Risks people faced were understood and managed by staff but risks around behaviours which could challenge needed to be included in people's care plans.

People received their medicines as prescribed.

People were supported by staff who had been recruited with safe

pre-employment checks.

Sufficient numbers of staff were deployed to meet people's needs.

People were protected from the risks of abuse by staff who understood the potential signs and were confident to report.

People were protected from the spread of infection by staff who understood the principles of infection control.

Lessons were learnt and improvements were made when things went wrong

Is the service effective?

Good

The service was effective.

People were asked to consent to their support and assessments of capacity and decisions were made in people's best interests where needed.

Staff received training and supervision to give them the skills they needed to carry out their roles.

The service worked with other healthcare services to deliver effective care.

People's needs and choices were assessed and effective systems were in place to deliver good care and treatment.

People were supported in an environment which was adapted to meet their needs with personalised rooms and accessible outside space.

People were supported to eat and drink enough and concerns about weight or fluid intake were effectively managed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were compassionate and kind in their approach.

Staff knew how people liked to be supported and offered them appropriate choices.

Visitors felt welcomed at the service and visited whenever they chose.

People and their relatives were listened to and felt involved in making decisions about their care.

People were supported by staff that respected and promoted their independence, privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Feedback about social opportunities and activities was not consistently positive but there were plans in place to improve opportunities for people

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

People received person centred, compassionate end of life care.

Is the service well-led?

Good

The service was well led.

People, relatives and staff spoke positively about the management of the home and the improvements in the service since our last inspection.

Staff felt supported and were confident and clear about their roles and responsibilities within the service.

Quality assurance measures provided oversight and enabled the service to identify good practice and areas for further development.

Feedback was used to highlight areas of good practice or where development was needed. Information was used to plan actions and make improvements.

Fairfield House Residential Care 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.

The inspection took place on 19 January 2018 and was unannounced. The inspection continued on 22 January 2018 and was announced.

The inspection was carried out by one inspector and an expert by experience on the first day and by the same inspector on the second 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. They had experience in dementia care and care home services.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority to obtain their views about the service.

We had requested and received a 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 reviewed this information prior to the inspection.

During the inspection we spoke with five people who used the service and three relatives. We also spoke with 11 members of staff and the manager. We spoke with two professionals who had knowledge of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection, these included seven care records. We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments, meeting minutes and staff training records. We looked at four staff files, the recruitment process, complaints, training and supervision records.

Following our inspection visit, we requested further documentation from the service. This included confirmation that some planned maintenance work had been completed, additional information about training for staff and contact details of relatives who had given consent for us to possibly contact them. This information was provided.

Good

Is the service safe?

Our findings

People generally received their medicines as prescribed. Staff administering medicines had received appropriate training and we observed that they explained what people's medicines were for. Where people had medicines prescribed to be taken 'as required', staff asked whether people wanted this before administering and recorded this accurately in the person's Medicine Administration Record(MAR). Further documentation was required for 'as required' medicines to provide staff with consistent guidance about how these medicines should be administered. The manager told us that they would ensure that these were put into place.

The service had safe arrangements for the ordering, storage and disposal of medicines. Where medicines required additional security checks, these were in place and stock balances were correct with records we saw. Some medicines required colder storage and this was provided with regular temperature checks in place. The home had experienced some issues with the pharmacy system they used and we saw that these had been identified and acted upon quickly to ensure that any issues did not impact on people.

People and relatives told us that they received safe care at Fairfield House. A relative explained that "it has lifted everyone in the family to know that (name) is safe and cared for". Another relative explained that staff had been concerned about a potential risk to their loved one and made changes to ensure that this was managed and the person was safe. One person told us that they felt "very safe, no problem", and another said they felt "perfectly safe". We observed staff supporting people safely throughout our inspection. For example, a person was walking with their frame. A staff member was walking with them, offering verbal encouragement and guidance and had a hand on the person's lower back to reassure them. Another person was supported to get up from their chair, when they struggled to do this; staff went and sought some equipment to assist the person. This ensured that they were supported to move safely.

Risk assessments identified the individual risks people faced and gave clear guidance for staff about how to manage these. For example, one person had a health diagnosis which meant that their abilities could vary from day to day. Their risk assessment described what a good day and a bad day would look like for the person and gave clear instructions for staff about what level of support was required to ensure the person remained safe. On a good day they were able to transfer using a frame and walk short distances, however on a bad day they were at a high risk of falls and needed different equipment and support to move safely. Staff were aware of the risks and supported the person in the ways described depending on their ability each day. Other risk assessments included whether people were at risk of falls, losing weight or developing pressure areas. Again these assessments gave clear instructions about how the risk affected the person and what support was needed to manage this.

Some people living at the home had behaviours which could challenge. There were no risk assessments in place to provide staff with clear guidance about possible triggers or consistent approaches to manage the risks that these behaviours posed to people and staff. For example, one person could become upset and this had resulted in a staff member being injured on one occasion. Behaviour charts were in place and documented when the person became upset and possible triggers. Staff told us their experiences about

what approaches were most likely to manage this risk and the manager had looked at patterns and trends in the behaviour charts. However there was no care plan in place to ensure that staff had clear guidance. The manager told us that they would put behaviour care plans into place to ensure that the knowledge and understanding around peoples' behaviours was recorded.

People were protected from the risks of abuse because staff understood the types of potential abuse and were confident to report. A staff member explained that they would be aware of "markings on bodies, changes in behaviours, agitation when this is unusual for the person". Because staff knew people well, they felt that they would be able to pick up on any subtle changes in how people presented as well as consider any physical signs such as bruising. The home had a safeguarding policy which provided contact numbers for external agencies including the local authority and out of hour's teams. Where safeguarding concerns had been raised, we saw that the local authority had been informed and notifications to CQC had also been sent. Recording paperwork for safeguarding included considerations of lessons learned from any allegations and the manager explained that this learning was shared with staff through meetings and supervisions.

Staff had access to enough suitable equipment to assist people safely. This was maintained regularly and also audited to ensure that there were no safety concerns. For example, slings required to hoist people to move safely were monitored to check there were no signs of wear or damage. We observed staff were able to access equipment people needed without delay and were confident using this to support people.

There were enough staff deployed to meet people's care and treatment needs. The manager used a dependency tool as a guide but told us "I speak with staff, discuss in supervisions". They explained that night staff had told them that they were finding nights stressful. In response to this the service were planning an additional staff member each night to assist in emergencies and for the early mornings and a twilight shift had been created for late evenings which was working well. People told us that they did not have to wait for assistance and staff felt that there were enough of them available to meet people's needs. Call bells were used by some people at the home and staff answered these promptly in most cases. The emergency call bell sounded on a few occasions and staff did not all seem clear about which staff needed to respond to this. For example, if staff were on a break. This did not delay people receiving support but the manager told us that they would revisit the expected responses with staff to ensure that they were consistent in understanding who needed to attend if an emergency bell was heard. We observed that staff had time to spend one to one with people and this promoted people's wellbeing. The service also employed cleaning and kitchen staff to ensure the service ran effectively.

Recruitment at the service was safe with appropriate pre-employment checks in place. Staff files included references from previous employers, identification checks and application forms. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. The manager told us that they did not have any vacancies but were still recruiting to reduce the risk of staff needing to work longer hours. They said "I want more staff doing less hours rather than less staff working more". Staff told us that they were asked if any emergency cover was needed and staffing rotas showed that staff were working a safe number of hours each week.

Fire evacuation procedures were in place and each person had a personal emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. There was an emergency plan which included contact details for local services including gas and electric companies. There were regular checks of the fire alarms, fire doors and fire safety equipment. Fire drills were carried out and recorded to ensure that people could be evacuated safely in the event of an emergency.

People were supported in an environment which was kept clean and safe with regular monitoring checks and cleaning. There were cleaning schedules in place to ensure that all areas of the home were kept hygienic and people were protected from the risk of infections. Availability of suitable personal protective equipment (PPE) such as gloves and aprons was monitored to ensure there were sufficient supplies and all staff had received training in infection control. The service had an infection control policy in place and procedures to manage any infection risks to people living at the home. Guidance included the use of Personal Protective Equipment (PPE) when assisting people with personal care or preparing or serving foods or drinks. Staff wore the appropriate gloves and aprons as outlined in the guidance and each person had PPE in their rooms for staff to use. One person's room had a strong malodour and we raised this with the manager. They confirmed that this had been reported, they had sourced suitable replacement furniture and that arrangements had been made to replace this on our second day of inspection.

Staff understood their responsibilities to raise concerns or report incidents and these were used to learn and drive improvements at the home. The manager told us about a previous safeguarding concern which had highlighted that there needed to be more robust systems in place to ensure the home's finances were securely managed. They explained the lessons that had been learned from the concern raised and actions which were subsequently taken to improve this. A person in the home had a cold and the manager had identified that there was no homely remedy policy in place to provide access for people to one off medicines such as throat lozenges or painkillers. They had developed a policy on homely remedies and at the time of inspection, this had been shared with staff for their comments before using this policy at the home. This demonstrated that the home used information about gaps or incidents to make changes and staff were involved in improvements and learning.

Good

Is the service effective?

Our findings

At our last comprehensive inspection on 27 September and 4 October 2016 we found there were breaches of Regulations 9, 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's care and treatment was not always appropriate or met their needs. Care and treatment was not always designed with a view to meeting people's individual needs. The registered persons were not acting in accordance with the Mental Capacity Act (2005) to ensure care and treatment of people was provided with consent. People's nutritional and hydration needs were not always met to ensure food and hydration was adequate, dietary supplements were not consistently given and people were not always provided with the support required to keep them hydrated. At this inspection we found that improvements had been made.

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 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 authorisation 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 whether any conditions on authorisations to deprive a person of their liberty were being met.

During this inspection we found that MCA and best interest paperwork was in place, complete and up to date. Where people had legal arrangements in place to manage decisions about their support, these were recorded and copies included in their care plans. MCA assessments were decision specific and included clear reasoning where a person had been assessed as lacking capacity. Decisions in people's best interests involved those important to them and considered whether options were the last restrictive for the person. For example, a person had an MCA and best interest decision relating to the use of bed rails. The decision in their best interest was that the use of a sensor beam would be less restrictive for the person and still manage the identified risk and this option was therefore agreed.

One person at the home had a DoLS authorisation in place which had a condition attached. The condition was that the home was to take the person out on a more regular basis, ideally once every two weeks. The manager told us that no-one at the home had any conditions attached to their DoLS and the activities staff were not aware that there was a condition for this person to be taken out regularly. This meant that the condition was not being met. The registered manager explained that the person's ability had deteriorated and following the inspection they provided confirmation that they had spoken with the local authority to amend the condition attached to the person's DoLS. They confirmed that they would be able to meet the revised condition.

The manager had records which showed which applications for DoLS had been made, which were awaiting assessment and which had been agreed. The manager advised that they would ensure that they also included whether DoLS had attached conditions to ensure that these were met.

People and those important to them were involved in assessments about their support. One relative explained that their loved one visited the home a few times before moving and this had enabled staff to assess and understand what the person needed and how they wished to be supported. Another relative said that they had been "impressed by the quality of the information" the home had about their loved one. They explained "They had learned everything about (name)" and had detailed information which they felt was important. Assessments included person centred details about how people wanted to be supported and included whether they had a preference of male or female staff. One person explained "I said I don't want a man (for personal care)….this was respected".

The service provided staff with regular training which related to their roles and responsibilities. Staff were knowledgeable about people's needs, preferences and choices. We reviewed the training records which confirmed that staff had received training in topics such as health and safety, moving and assisting, infection control and prevention and first aid. The manager explained that they had identified an issue with their training matrix and were working to ensure that all the dates recorded were accurate for completion of training and when training was next due. This was already underway at the time of inspection and any outstanding training was booked in for completion.

Senior staff had attended Parkinson's training and this was in the process of being completed by other staff at the service. This was relevant because some people living at the home had Parkinson's disease. Other training was offered in care planning and Autism which was relevant for people living at the home and had been identified by staff as areas for further learning. The manager explained that they were focussing on encouraging staff to undertake national qualifications and several staff were progressing through levels 2 and 3 of national health and social care training. Senior staff were being supported to undertake national leadership qualifications.

New staff to the home were supported through an induction and probation period and completed the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. A staff member told us that they had shadowed other staff as part of their induction and that the senior staff usually provided shadowing support for new staff joining the team.

People were supported to have a balanced diet and where people needed foods prepared in a certain way to eat safely, this was accommodated. People spoke highly about the meals at the home and had a choice about what they ate. The chef told us about people's preferences and explained that they planned the menus and responded to how meals were received by people. If feedback indicated that a certain choice was not liked, this was removed from the menu. Meals were presented well with attention to detail such as pasta served with a salad on the side, or mashed potato for one person because they did not want chips. Some people had different cutlery and plates to assist them to eat independently and we saw that people were supported to eat themselves rather than staff offering full assistance. For example, a person was assisted to put food onto their spoon and the person was then able to eat this without staff assistance. People chose where they wanted their meals and those who ate in the communal dining room chose who they sat with. Puddings were displayed on a trolley so people could make a choice based on what they saw. This was particularly helpful for people who had a dementia as they could identify choices visually. The trolley was also taken round to people's rooms so that people could visually pick an option.

People were supported to access snacks outside of mealtimes if they wished. There was a snack box

available in the lounge of the home with choices including fruit, crisps and biscuits. During the inspection we observed one lady walk across the lounge and choose some biscuits to eat.

People were supported to receive effective care and treatment because Fairfield House worked with other organisations and teams to provide joined up care. One person was reluctant to accept support and staff were concerned about the impact on their health and welfare. They involved the local authority and mental health teams and had been involved in meetings with other professionals and the family to consider how to best support the person. This joined up approach meant that care was effectively planned to consider how to best communicate with the person and what approaches to use.

People were supported to access health care services when needed. A health professional spoke positively about the home and said "Fairfield are very good at referring… (referrals) are made appropriately and in a timely way". We saw that a referral had been made for one person who was unwell and anti-biotics had been prescribed. Another person was not very well on our first day of inspection and the GP surgery had been contacted promptly. People also received visits from chiropody and were assisted to attend health appointments where needed, for example, for eye checks.

People were supported to access appropriate spaces in the home when they wished to do so. The majority of people spent time in the communal lounge and dining areas of the home. There was a separate conservatory people could access and outside space including paved areas, garden and a path around the property. One relative explained that the outside space had been a factor in why they had chosen the home and they walked with their loved one when they visited. Bedrooms were identifiable by door numbers only, but handrails were painted in contrasting colours which assisted people with sight issues or dementia to use these to walk around. People had personalised their rooms, some with furniture and we saw photos, paintings and other personal items displayed in the rooms we visited. Toilets had pictorial signs to assist people to identify these. Boards around the home displayed activities which were planned each day, menu choices and photographs of previous activities were also displayed.

Good

Is the service caring?

Our findings

People and relatives told us that staff were kind and compassionate in their approach. One person explained "Oh yes they are (kind)… (name) is the senior carer...they do everything to help me. Any bits they say 'that's not right, I'll deal with it'". Another explained "I've said to friends, they (staff) are remarkable people, nothing is too much trouble". A relative told us that staff were caring and said "very much so, they helped (name) settle in" when they first arrived at the home. Another explained that the best part of the home was "the carers themselves have a great attitude and are interested in (name) and like telling me how (name) has been ". We observed that staff cared about the people they supported, they interacted with them using tactile contact to reassure and engage people and used appropriate humour.

One person had been unwell when we visited; we observed staff communicating their observations about the person to each other and saw that the surgery had been contacted promptly to ask for a GP to visit the person. Another person had difficulty communicating. The home had involved external professionals to understand how to effectively communicate with the person and how to understand their body language. Staff had contacted the person's relative to seek information about their history and what would have been important to them before they moved into the home. A staff member told us how they had put this knowledge and learning into practice to support the person.

Staff understood people's preferences and respected their choices. One relative told us that their loved one's appearance was extremely important to them and we saw that staff had assisted them to put on jewellery as their relative had described. One person preferred to take their own medicine in the morning, Staff had arranged this so that they woke the person at the time they preferred so they could take their medicine. A married couple lived at the home and were given choices about how they lived and spent time together. Their choices were respected and they explained "we like to hold hands….they (staff) don't interfere at all. They just call us the lovebirds". They were afforded privacy when they wanted this and felt supported by staff in their relationship.

People's religious and cultural needs were respected. People at the home received regular visits from a local church and staff explained how they were mindful about people's cultural and religious needs and would ensure that these were respected and that people were encouraged to maintain links with the community if they wished to do so. Staff had training in equality and the manager explained that where people at the home had protected characteristics under the Equality Act, they would "raise awareness and make it clear to everyone what was acceptable…ensure understanding and respect for one another".

People's privacy was respected and staff encouraged people to be as independent as possible. We observed staff knocking on people's door and seeking consent before they entered their bedrooms. Staff explained how they protected people's privacy when they supported them with personal care. One told us "I never leave people uncovered, even in the bath we try to keep partly covered. This also stops people from getting cold and upset".

Visitors were able to visit whenever they chose and were welcomed at the home. Fairfield House had a staff

member who was seated in the main foyer at the home and greeted people and visitors when they arrived. This was appreciated by relatives and professionals we spoke with who felt that they were greeted warmly and that this set a welcoming atmosphere at the home. One relative told us "I'm part of the furniture, like part of the family; they are very supportive to me". Another explained "we are absolutely welcomed whenever we go…really can't fault them, every member of the staff team has been brilliant".

Good

Is the service responsive?

Our findings

Feedback about social opportunities and activities was not consistently positive but there were plans in place to improve opportunities for people. Of the eight people and relatives we spoke with, four felt that there was not enough to do or nothing which interested them. One person told us "Nothing much (goes on), I don't know whether they're going to have any activities…I haven't been to any". Another person said activities were "mainly based on what goes on in the lounge. TV, games". A relative described activities as "hopeless…very rarely do I come in and anything is going on, especially afternoons and weekends". There were planned activities displayed in the home but these included times for "chatter" and "evening news". We observed a craft session which five people were engaged in and a quiz where some people were engaged in the communal lounge. However, of the 28 people living at the home, the majority did not take part in group activities and activities staff had limited one to one time with people.

One of the activities staff told us that the managers understanding of activities was good and that activities had improved since the new manager had come into post. The manager explained that activities were planned to change and explained about staffing plans to provide increased activities staff time. They explained that when they started in post, they were told that the home did not have a Christmas party. The manager arranged a Christmas party with staff for people and their loved ones and this was enjoyed and was planned to be an annual event. The manager had plans to develop more frequent events to involved relatives and families, including ideas such as themed suppers. They also wanted to encourage people and staff to arrange some fundraising events and was in the process of arranging for staff to provide hand massage and manicures weekly as several people liked this. Other feedback comments were positive and included "Seem to be things going on and (name) talks about things they have been doing". Another person told us how they enjoyed painting. This had been listened to and the manager had sourced an external painter to visit regularly and run sessions for those who enjoyed painting, we saw pictures on display from these sessions.

Fairfield House had a minibus which was available to support people to go out. At the time of inspection this was not being used. The manager explained that they had a temporary issue accessing staff who were be able to drive the minibus. This was in the process of being resolved and regular trips were planned for people who wanted to go out.

People and those important to them were able to contribute to planning their care and support through regular involvement in reviews and informal updates. Care plans were reviewed monthly and this included a summary of any feedback received or the views of people or those important to them during the previous month. A relative explained that they had been contacted when their loved one had fallen. After this, the home discussed a possible change in room to one closer to the communal areas to reduce the risk of further falls and increase staff monitoring. The relative explained that the change was discussed with the person also and had been a positive change. This meant that care and support was responsive to people's changing needs.

People had personalised care plans which detailed information about how they wanted to receive support. Care plans included details about people's emotional and social needs, including on the grounds of protected characteristics under the Equality Act. Details included a history of the person, their interests and hobbies and information about what was important to people and or what might worry or upset someone. For example, one person would be concerned about any males going into their room. Staff were aware of and respected this.

People's communication needs were identified and where people had a sensory loss, staff were aware about how to support them. For example, the care plan for one person explained that they had sensory loss and staff needed to assist them to use their telephone by dialling the numbers and putting the phone onto loud speaker. Another person used an electronic device to maintain contact with their loved one and the home had improved their Wi-Fi access to ensure the person could communicate in this way from their bedroom. Another person explained that the manager had spoken with them and offered to purchase a piece of equipment to aid communication. The person told us this would be "a big improvement".

People and relatives told us that they would be confident to raise any concerns or complaints and that they would be listened to. We saw that complaints had been acknowledged, investigated and responded to and that learning from these had been shared. There was a complaints policy which provided details about external agencies including CQC and the Ombudsman and also gave timescales for each stage of the complaint process which had been met for the complaints we looked at. One person explained "Yes, I'd had a little complaint…I made my feelings known and it was actioned". Another person told us "I may have complained, they always act".

People received personalised end of life care which took into account their preferences and wishes. Care plans included details of conversations with people and those important to them and any views were noted. For example, one person wanted to have fresh flowers and music playing while another did not have specific wishes but was concerned about a loved one and how they would cope when they passed away. These wishes were regularly reviewed and included details about DNAR decisions and involvement of people's relatives and loved ones. One person had passed away at the home shortly before our inspection. The manager explained how they had supported the family after the person had died and had encouraged staff to speak with them or contact their employee assistance programme for support if they wanted to speak with someone outside the home.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection on 27 September and 4 October 2016 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems were not always in place to ensure concerns were picked up and met through the quality assurance process. At this inspection we found that improvements had been made.

The service did not have a registered manager in post at the time of inspection. However the manager had applied to CQC and since our inspection they confirmed that they had successfully registered.

People, relatives and staff spoke extremely positively about the changes since the new manager had come into post. Staff consistently told us that they felt better supported and that the staff team worked more effectively together. One staff member told us "the atmosphere is much better…things are improving". Another explained "it's happier, a calmer environment and a pleasant place to be". One person told us "I think (manager) is making improvements, (manager) is just getting into it". A relative told us that the manager was "very good, very approachable…says what (manager) is going to do and sticks with it". Staff felt able to speak with the manager and told us that when they had needed to raise any concerns or issues, these had been listened to and acted upon. The manager told us that they monitored the hours that staff were working to ensure that they were supported and did not work excessive hours each week.

Staff understood their roles and responsibilities and communicated well verbally and through handovers and team meetings. We observed staff updating each other about people throughout our inspection and saw that handovers took place at shift changes. Written records of these included details about how people were and any changes staff needed to be aware of. For example, if a person needed to see a health professional or seemed unwell and needed closer monitoring.

The manager explained that they were working with staff to encourage and enable them to be involved in decisions about the service. They also felt there had been improvements in teamwork at the home. At the time of inspection, the manager was reviewing existing policies and considering implementation of new policies where gaps were identified. They explained that they gave draft copies to staff for their comments and feedback before agreeing any changes. They had encouraged senior staff to undertake learning and development to provide them with the correct leadership skills to be effective in their roles.

Fairfield House had an employee of the month system in place where staff could anonymously enter colleagues where they felt they had gone above and beyond. The manager told us about the staff member who had received this most recently at a staff meeting. There were plans to change the system so that people were also able to feedback about staff they felt deserved this acknowledgement. They explained that they were going to use staff photos to assist people to visually identify staff they wanted to nominate. This suggestion had been made by staff during supervision and had been listened to and acted on by the manager.

The manager told us that they received regular support and supervision from the provider and were in the

process of building up links with registered managers of other homes and other local resources. They had contact with the local authority and had worked with other agencies when planning care support for people. The manager sought advice from the local safeguarding teams where needed. They were also in the process of compiling an overall action plan for the service to being together planned improvements, changes and current work in one document. Feedback from staff had indicated that they felt that there was too much paperwork required in their roles. The manager explained that there were plans to trial an electronic system which would be accessible to staff on mobile devices and could make recording more manageable.

Quality assurance systems were in place and used to identify gaps and trends to improve service delivery. There was a system of delegated responsibilities for oversight systems which meant that staff had clarity about their roles and how these fitted within the governance of the home. We saw that there were regular checks including availability and use of PPE, checks on equipment people used, spot checks of night shifts, checks that people's pressure mattresses were set according to their weights and analysis of accidents and incidents. Where gaps or issues were highlighted, these were actioned. For example, an audit of commodes people used had shown that some needed additional cleaning which was completed on the same day.

People, relatives and professionals were encouraged to feedback and be involved in improvements at the home. There were regular resident and relative meetings and surveys which were used to identify and make changes. Surveys had been sent out to relatives, visitors and professionals in 2017 and we saw that 16 had been returned. Feedback was positive and included several comments about improvements at the home. These included a relative who reported 'very noticeable improvements….previously I had to seek out staff but now I find staff ring me and discuss any matters of concern'. Another relative had suggested that some people at the home would prefer an alternative alcoholic drink option with their meals as this would have been their preference before moving to the home. This had been acted upon and this option was available for people. Feedback from one professional stated 'I spend a lot of time on a one to one basis with the residents; they are always happy and chatting'. They went on to state 'We highly recommend Fairfield to people considering going into care… (there is) a clear structure and hierarchy of responsibility'. Another professional explained 'the best care home on all levels I visit. If my parents had needed a care home – Fairfield would have been my choice'.