Caldwell Care Limited

The Firs

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 3 and 6 October 2014 and was unannounced.

The Firs Care home provides accommodation for up to 22 older people who are physically frail or may be living with dementia. At the time of our inspection there were 20 people living at the home. The home provides long term care, respite care and day care. It does not provide nursing care. Most people needed assistance with managing daily routines such as personal care. A small number of people routinely needed support with eating or support with moving and positioning. The home is located in a residential area of Locks Heath. There is a small car park located at the front and there are accessible gardens. The accommodation is arranged over two floors and there is a lift available for accessing the first floor. There are 16 single rooms and three shared rooms. All of the rooms have en-suite facilities.

The Firs has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

There were systems and processes in place for managing people's medicines, for example staff had received appropriate training. However the systems were not effective in ensuring that medicines were administered, stored and disposed of correctly.

Risks to people's safety were identified and managed effectively. However some risk assessments contained conflicting or out of date information. Some risk assessments needed to be more detailed about the actions staff needed to take to ensure that people were protected from harm.

There were some quality assurance systems in place to monitor and review the quality of the home. However these needed to be more robust to ensure that they were an effective tool in identifying any shortfalls or areas for improvement.

There were sufficient numbers of suitably qualified staff. Some staff told us that at times they felt that care could be enhanced further by having some additional staff on duty. Three people told us that at times, there could be a slight delay in staff being able to assist them as they were busy supporting other people. New staff had been recruited to ensure that staffing levels remained responsive to the needs of people using the service.

Safe recruitment practices were followed which made sure that only suitable staff were employed to care for people in the home.

People told us that they felt safe and we saw that there were systems and processes in place to protect them from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team. Staff were aware of the importance of disclosing concerns about poor practice or abuse and were informed about the organisations whistleblowing policy

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Staff understood how the Mental Capacity Act (MCA) 2005 was applied. Mental capacity assessments had been undertaken which were decision specific. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as GP's and relatives to ensure that decisions were being made in the person's best interests.

People told us that their staff members provided them with the support they needed. Staff told us that the registered manager supported them to develop their skills and knowledge by providing a programme of training which helped them to carry out their roles and responsibilities effectively. Staff received regular supervision which considered their development and training needs.

Staff worked effectively with healthcare professionals, for example, links had been developed with the continence service to help ensure that staff were following best practice guidance. People were supported to see healthcare professionals such as GP's, chiropodists, community nurses and opticians.

People were positive about their care and the support they received from staff. Interactions between staff and people which were kind and respectful. Staff were aware of how they should respect people's dignity and privacy when providing care.

Staff were aware of what people needed help with and what they were able to do for themselves. They supported and encouraged people to remain as independent as possible.

People's preferences, likes and dislikes had been recorded and we saw that support was provided in accordance with people's wishes. People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide, including how to raise concerns with the Care Quality Commission. People were confident that any complaints would be taken seriously and action taken by the registered manager.

There was a programme of activities in place which people seemed to enjoy, although some health and social care professionals told us that they felt the activities offered could be more diverse.

Summary of findings

The registered manager who actively sought feedback from people and staff in order that improvements could be made to the home. The registered manager told us that the provider visited the home frequently and was supportive of the management team which included provided the resources needed to effectively meet people's needs.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Whilst people told us that they felt safe living at The Firs, we found that the service did not have appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines.

There were staff available in sufficient numbers to meet people's needs and provide person centred care, although, some people told us that at times, there could be a slight delay in their needs being met.

Staff had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place.

Recruitment practices were safe and that relevant checks had been completed before staff worked with vulnerable people.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the necessary skills and knowledge to effectively meet their assessed needs. Staff received an appropriate induction to the home and training relevant to their role.

People were asked for their consent before care and support was provided. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people to ensure that decisions were being made in the person's best interests.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and we frequently observed staff encouraging people to drink fluids.

The home had developed effective working relationships with a number of health care professionals to ensure people received co-ordinated care, treatment and support.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. Staff treated people with dignity and respect and people appeared relaxed and comfortable in the presence of their carers. Staff clearly knew people well and spoke with them about the things that were meaningful to them.

Summary of findings

People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Support was not always provided in a manner that was responsive to people's individual needs.

People were provided with the opportunity to take part in a programme of activities which they appeared to enjoy.

Where necessary action was taken in response to changes in people's needs. This ensured that people were enabled to have access to care, treatment and support when they needed it.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide. People were confident that any complaints would be taken seriously and action taken by the registered manager.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were some quality assurance systems in place to monitor and review the quality of the home. However these needed to be further embedded to ensure they were an effective tool for assessing the on-going quality and safety of the care provided to people.

There was an open and transparent culture within the home and the engagement and involvement of people and staff in planning and developing the home was promoted

The Firs

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 was completed over two days on 3 and 6 October 2014 and was unannounced. The inspection was carried out by an inspector.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. Before the inspection, the provider completed 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 used this information to help us decide what areas to focus on during our inspection.

On the day of the inspection we spoke with six people and four relatives. We also spoke with the registered manager, the deputy manager, six care staff and the chef. We reviewed records relating to the management of the home and reviewed four staff records. We also reviewed records relating to five people's care such as their care plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences due to complex needs, we used other methods to help us understand their experiences, including observation of their support. For example, 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.

Following the inspection we spoke with four community health or social care professionals to obtain their views on the home and the quality of care people received.

The last inspection of this service was in August 2013. This found that recommendations from a electrical safety inspection had not all been completed within the relevant timescales. The registered manager arranged for the recommendations to be completed and provided us with evidence that this had been done shortly after the inspection.

Requires Improvement

Is the service safe?

Our findings

Each person we spoke with told us they felt safe living at The Firs. One person said, "Yes I feel quite safe". Throughout our visit, we saw that staff and the management took time to talk with people, reassuring them which seemed to support them to feel safe and secure.

Whilst people told us that they felt safe living at The Firs, we found that the home did not have appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines.

Medicines which included insulin were kept in a fridge which was also used for food storage. Guidance by the Royal Pharmaceutical Society 'The safe handling of Medicines in Social Care', states that medicines should be kept in a separate secure fridge, or in small homes, in a separate fridge, when there is a constant need to refrigerate medicines such as insulin. We found that the medicines were stored in an uncovered and un-lockable container. Some medicines must be stored in a fridge because at room temperature they start to break down or become less effective. The temperature of fridges used for the storage of medication should between 2°c and 8°c. The temperature of the medicines fridge was being checked daily and appeared to be within range which helped to ensure that the medicines remained safe to use. However the records of the fridge temperatures needed to be more robust as the service had two fridges and it was not clear which of the two fridges the temperature readings related to.

There were gaps in four people's medication administration record (MAR) where staff had not signed to confirm whether a medicine had been administered. Therefore adequate records were not always being kept to demonstrate that people were receiving their medicines safely. Some people were prescribed medicines to be taken 'when required'. We looked at a care plan for one of these people. This did not contain detailed guidance for staff members about when to give the medicine. However when we spoke to staff they were able to consistently tell us about the signs and symptoms which might indicate the medicine was required.

Medicines should be used in the order in which they were dispensed and surplus or unwanted medicines should not be kept for longer than is necessary. Arrangements were in place to dispose of medicines correctly, but this had not always been completed in a timely manner. For example a person had stopped taking a particular medicine in May 2014, but the surplus had not been returned to the pharmacy by the time of our inspection in October 2014. One person's eye drops which should have been discarded 28 days after opening were still being administered 32 days after opening.

The home had arranged for a pharmacy audit to be undertaken and had recently started to undertake internal audits to check that the medicines were being handled safely in the home. These audits did not fully record the outcome of any investigations or actions undertaken as a result of the audit that had been completed. The audits had not identified the issues that we found. Therefore we could not be assured that the medicines administration systems were monitored effectively to ensure that people received their medicines as prescribed.

People's medicines were not managed safely. The registered manager had not ensured that people's medicines were administered, stored and disposed of correctly. This is a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

We observed a senior staff member administering medicines to people using the service. The senior staff member either handed the medicines to the service user or administered the medicines as preferred by the service user. One person was receiving disguised or covert medication. We saw that this was only done after appropriate mental capacity assessments had been completed and it had been agreed by relevant persons that this was in their best interests.

Appropriate arrangements were in place in relation to obtaining medicine which helped to ensure that medicines were available when people needed them. Medicines were stored safely in locked cupboards and trolleys which only the senior carer had access to on each shift. Controlled drugs which are medicines that require a higher level of security were stored in appropriate cupboards. We looked at the records for these medicines and saw that they were accurate.

A range of tools were being used to assess and review people's risk of poor nutrition or skin damage. Measures had been put in place to address identified risks for one

Is the service safe?

person where aspects of their behaviour placed them at risk of harm. We saw a detailed moving and handling risk assessment and risk assessments in relation to the use of bed rails. Other risk assessments were recorded on a resident risk assessment document. This considered the level of assistance people needed with a range of tasks such as using the toilet, eating and drinking or moving around the environment. We found that these risk assessments were not always specific enough and did not contain sufficient details about how identified risks should be managed. We also saw two examples where the information in the risk assessment was out of date and did not reflect the person's current needs. This was despite the fact that the assessment had been reviewed monthly. This meant that the arrangements for reviewing the assessments was not always effective at ensuring that these remained up to date and accurate.

People using the service gave mixed feedback as to whether there were always sufficient numbers of staff on duty. Four people told us that there were sufficient staff available to support them when they needed it. Two people told us that at times there was a delay in their call bells being answered. One person told us, "sometimes there is not enough staff… in the evening I can have to wait for help to go the toilet…they are busy helping people to bed". Another person said, "Sometimes they don't come very quickly when I press my bell, they are all busy". A relative told us "There have been occasions when we have felt that staff are a bit pushed".

Feedback from staff was also mixed. The majority told us that the staffing levels were adequate. One staff member said, " yes there are enough staff, there is some sickness, you are asked to cover but not too much…things always get done, it can be hard, but we do it. Another staff member said, "Yes there is usually enough staff… a couple of people have left recently, but we always try to ensure there are three people on duty". A third staff member said, "There is not enough staff all of the time". They explained that essential care was always done, but that things like activities might not happen, they said, "We might just have to put music on instead". A fourth staff member said, "There are usually enough staff….the management team always try their best….do everything they can including providing care and support themselves where needed".

Staff employed to work at the home included a registered manager who was supported by a deputy manager. Care was provided by a team of senior staff members and staff members. A maintenance person, cooks, and housekeeping staff were also employed. The ancillary staff all appeared to have a good relationship with people and readily engaged with them whilst undertaking their duties, which helped to promote a positive atmosphere within the home.

The registered manager was confident that they had a good understanding of the number of staff required to deliver a safe service. The target staffing levels for day shifts were one senior staff member and two staff members, supported by either the deputy or registered manager. At night there were two waking staff members on duty. The registered manager explained that the home were currently recruiting staff members but that there had been no need to use agency staff members for some time. They advised that the existing staff team covered gaps in the rota and that this worked well. This helped to ensure that people received care from consistent staff who were familiar with their needs. During the day the care staff were supported by housekeeping and kitchen staff. A cook was on duty until 5.30 which allowed them to prepare supper and assist with serving this before leaving for the day. This helped to ensure that care staff could focus on supporting people.

Staff rotas showed us that on six occasions during the previous three weeks, the home had not been staffed at the target levels, as determined by the registered manager, for periods of time. These gaps were generally between the time of 6pm – 8pm. The registered manager told us that these problems had arisen due to staff not giving adequate notice of their absence. We were told that in response to these situations, the deputy manager would often stay late to assist in the provision of care, but this was not always evidenced on the rotas.

Staff responded quickly and people's needs were met in a personalised and timely manner, although we were aware, particularly over the lunch-time period that some people experienced a short delay in being supported to eat their meals whilst staff were engaged helping other people. We spoke with the registered manager about the feedback from people and staff. They told us that they felt current staffing levels were adequate but that they always had the flexibility to increase staffing levels if this was required in

Requires Improvement

Is the service safe?

response to people's needs. They explained that they had recently had a number of admissions for respite care and in light of our feedback would give further consideration to the impact of this on staffing levels.

Staff had received training in safeguarding vulnerable adults and were required to repeat this on an annual basis. Staff had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place. One staff member told us, that their priority was the safety of people using the service.

The Safeguarding Adults Multi-agency Policy, Procedures and Guidance was available within the home and contained relevant information about how to raise safeguarding alerts including contact details. We saw that the provider also had an "Adult Protection Policy", which staff confirmed they had read. We did note that this policy needed updating as it contained references to out of date guidance. The registered manager told us that safeguarding people from abuse was discussed with staff in their supervisions where scenarios were used to encourage staff to reflect upon how they might act to keep people safe.

Staff were informed about the provider's whistleblowing policy. All of the staff we spoke with were clear that they could raise any concerns with the manager of the home, but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

The service was implementing a personal emergency evacuation plan for each person using the service. This detailed the assistance and equipment that they would require for safe evacuation. The provider had an emergency and crisis plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home which meant that people using the service might have to be temporarily relocated to alternative accommodation. This did not include contingency plans for other events which might affect the continuity of the service such as loss of power or loss of significant numbers of staff or bad weather.

Recruitment and induction practices were safe and relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service checks (DBS) were now being completed before staff worked unsupervised. DBS checks help employers make safer recruitment decisions and help prevent unsuitable people working with people who use care and support services. We did note that in two of the staff records a full employment history had not been obtained. We spoke with the deputy manager about this who obtained this information during the inspection.

Good

Is the service effective?

Our findings

People received effective care and support. One person said, "I have nothing to complain about, the staff are always helpful". Another person and their relative told us, "Its brilliant care, we are very happy". People told us that the staff seemed well trained and had the right skills and knowledge to care for them. This was echoed by relatives who told us, "There is a good core of staff, they seem to get a lot of training" and "staff generally seem competent".

When staff started work at the home, they received an initial induction which included shadowing more experienced staff and covered their familiarisation with the environment, the people living at the home, and the policies and procedures of the organisation. New staff were enrolled on the Skills for Care's Common Induction Standards (CIS). These are the standards people working in adult social care should meet before they can safely work unsupervised. They are designed to be met within 12 weeks to enable staff members to demonstrate their understanding of how to provide high quality care and support. We did note that the CIS were not always being completed within the 12 weeks. The registered manager told us that this was due to some staff needing additional support or mentoring, but that their completion remained a priority for the service and would be monitored though the staff member's supervision. The majority of staff had been employed at the home for some time which meant that the staff team was stable and this helped to support the delivery of consistent care by staff who were familiar with the needs of people.

There were arrangements in place to ensure that staff received appropriate training such as moving and handling, first aid and fire training. Some staff completed additional subjects such dementia care, end of life care and tissue viability. We saw that arrangements had been made for a senior member of the organisation to act as an in house trainer so that they could deliver training to the staff team in a timely and responsive manner. We saw that following an incident where a member of staff had used inappropriate moving and handling techniques, retraining and reassessment of their competency was undertaken immediately.

All of the staff we spoke with said they received regular supervision and an appraisal of their performance. Records showed this to be the case. Staff told us that supervision was an opportunity to consider their personal development. We saw that topics such as their competency, their key worker responsibilities and the importance of whistleblowing were also discussed. Staff told us that supervision was very helpful. One staff member said, "You can talk about problems, they are very understanding".

People were asked for their consent before care and support was provided and staff were clear that when people had the mental capacity to make their own decisions, this would be respected. The home also cared for a number of people who were unable to give valid consent to the care provided by the home and so we checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act is a law that protects and supports people who do not have the ability to make decisions for themselves. Staff had received training in the MCA and were able to describe some of the key principles of the Act.

Mental capacity assessments had been undertaken which were decision specific. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as GP's and relatives to ensure that decisions were being made in the person's best interests. This meant that the home had ensured that people's rights under the relevant legislation were being upheld.

We saw that some care plans stated that the person had appointed a personal welfare attorney, but the home had not obtained a copy of this for their records. This is important because if a person has created a personal welfare lasting power of attorney, then this attorney is the decision-maker on all matters relating to the person's care and treatment. The home needs to be confident that they have current and accurate information about this so that relevant people are involved and consulted about the person's care and support needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager understood when an application should be made and was

Good

Is the service effective?

aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Relevant applications had been submitted and staff were aware of which people were subject to a DoLS and the restrictions these authorised.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and we frequently observed staff encouraging people to drink fluids. The meals were home cooked, freshly prepared and well presented. One person told us, "The food is always very nice....there is always fresh vegetables….the chef comes around and offers us a choice, everyone has their say". Their relative said, "They know what mum does not like". Another person told us, "The food is always very good and that there are always plenty of drinks available". We saw that information about people's likes and dislikes in relation to food was kept in the kitchen and regularly updated. The chef was informed about people's allergies and special diets. They told us that when making a pureed meal, they ensured that each of the elements of the meal were pureed separately so that the person could still taste the individual flavours. They said they were kept informed if people were losing weight so that they could fortify their diet with high calorific foods such as cream.

People's nutritional needs were assessed and their weight recorded on a monthly basis to help make sure that people were getting enough to eat and drink. Where people had been assessed as being at risk of poor nutrition, food and fluid charts were being used to monitor how much they ate each day. Staff were able to describe in detail the signs and symptoms which might indicate that a person was dehydrated. One staff member told us, "Because we know our residents, we pick up quickly if they are not eating and drinking, this is then communicated effectively to the whole team, and I can't fault the communication".

The home had developed effective working relationships with a number of health care professionals to ensure that people received co-ordinated care, treatment and support including GP's and mental health nurses supporting those living with dementia. For example, links had been developed with the continence service to help ensure that staff were following best practice guidance. People were able to see their GP when they wanted to along with other healthcare professionals such as chiropodists and opticians. We saw that referrals were made promptly to relevant health services when people's needs changed. For example, we saw that one person who was having swallowing problems had been referred to a speech and a language therapist. A health care professional told us that they had "Always found the staff helpful and professional". Another said the home had "Always acted on their advice and instructions". This showed that people's day to day healthcare needs were met and when people's needs changed, referrals were made quickly to relevant healthcare services.

Good

Is the service caring?

Our findings

People told us that they were well cared for. One person told us, "They [staff] are kind and caring". Another person said, "They are always very helpful, very attentive, its very family orientated here". A third person told us, "There is nothing to grumble about, they [staff] are very good to me, and everything is quite good". We saw feedback from a relative which read, "We were made to feel at home". Another relative had written to say thank you for the way that staff had cared for their relative with "patience, dedication and a friendly attitude….they genuinely loved and cared".

Staff told us, the home was "homely not clinical, a home from home". A healthcare professional described to us how they felt the manner with which the home had provided end of life care to a person had been "touching and warm". They explained how they had welcomed the person's family into the home and had fully respected the person's end of life wishes.

People were supported by kind and attentive staff. Staff were courteous and people appeared relaxed and comfortable in the presence of staff. Staff clearly knew people well and spoke with them about the things that were meaningful to them. For example, staff told us how they encouraged one person to talk about their love of animals as a way of distracting them when they were feeling agitated or in low mood. One staff member told us, "Making the residents happy makes me happy, it means I have a good day".

Staff members and the management team effectively communicated with people. Staff who passed by stopped and spoke with people, reassured them, or shared a joke. A social care professional told us that they observed that staff "took the time to listen and respond to people's needs and questions. This showed that staff tried to make people living in the home, their priority, effectively balancing this against the need to complete other tasks.

People were involved, where able, in decisions about their care and their views were listened to which helped them to retain choice and control over their care. We saw that where able, people had signed their care plans to confirm that staff had talked to them about their care and support needs and that they had been involved in writing the care plan. A person told us, "I am quite happy, I am able to do what I want, and I am treated kindly". Where people were unable to express their views and wishes, relatives were involved in decisions about their care.

Staff members talked to us about the importance of listening to people's views and respecting their choices. One staff member said, "Choice is important, I encourage people to express their choice as much as they can, it may be just about what clothes they want to wear, but that's important". A health care professional told us, "During my visit, the deputy manager showed respect to [the person] and all the people we spoke with, they took time to listen and respond to their needs and questions".

People were treated with dignity and respect. The registered manager told us how they regularly observed staff practice to ensure that they were being careful to close doors when providing personal care and knocking on people's doors before entering. They explained that questions about the importance of dignity were part of the interview and selection process which helped to ensure that they employed people with the right aptitude and values for working within the home. We saw that the importance of maintaining people's privacy and dignity was also encouraged within peoples care plans. This helped to ensure that there was a culture of compassionate care within the home underpinned by the values of privacy and dignity.

Staff told us that where possible, they encouraged people to care for themselves, even if this was by completing a small task. One person told us, "They [staff]try to get me to do things myself…they walk behind me to give me confidence". A staff member told us, "When I assist someone with their care, I try to encourage them to do as much as they can and then I will help them with the rest. Another staff member said, "I always get a shoe horn so that [person] can put their shoes on themselves."

People's relatives and friends were able to visit without restrictions. We observed relatives visiting throughout the day and sharing in aspects of their relatives care and support. They appeared to have a good relationship with the staff. A social care professional told us how the welcome extended by the home to one relative had helped them to cope during the early period of their loved one being admitted to the home. They said that the welcome had "made a very hard period of time a lot easier".

Requires Improvement

Is the service responsive?

Our findings

People told us they were aware of their care plan and had felt able to be involved in decisions about how their care was managed.

Support was not always provided in a manner that was responsive to people's individual needs. We observed the lunch-time meal on two occasions. On the first day we found that staff although kind and considerate appeared un-coordinated and this resulted in some people experiencing a disjointed mealtime. For example, meal service began at 12.10pm, however one person did not receive their meal until 12.35pm. One person required a plate guard to help them eat independently. A plate guard is a curved gadget that can be fitted to plates to prevent food from falling off the plate and can be used as a barrier to push food against when scooping food onto a spoon or fork. However when this person was given their meal, the plate guard was in the wrong position and so they were not able to eat independently. We observed one staff member supporting two people to eat at the same time. This is not a personalised approach to delivering care.

People's needs were assessed before they moved to the home and this information was used to draft an initial care plan which was then regularly reviewed and updated as their needs changed. Each person had an individual care plan in relation to a range of needs such as personal hygiene, eating and drinking, continence care, medication, mobility and activities. Where appropriate people also had a dementia care plan which contained some guidance about interventions and approaches that staff could use to support people living with dementia. Information in the care plans was mainly task orientated but did contain some information about people's preferred daily routines. Staff told us that care plans helped them to deliver effective care. One staff member said, "The plans are very up together, we are always being encouraged to read them to stay informed". Another staff member said, "The care plans are brilliant. really detailed". A third staff member said that the care plans helped them to know the needs of new residents or those coming to the home for respite. They said, "I have the information I need, we have strategies that work".

Staff had worked with people and their families to create a life history which was used to inform the assessments, care plans and interventions. Plans also contained information about people's preferred daily routines, for example, we saw that people had expressed their preference about when they liked to get up or go to bed. One plan detailed how the person liked to have music on in the morning and another person's plan reminded staff to be mindful not to splash water on the persons face as they did not like this. A staff member told us however that they still checked each time care was provided about people's preferences, they said they did not want to assume that they always wanted to same thing.

Staff were developing end of life care plans which were an opportunity for the person to express and record their wishes, choices and preferences about their care when approaching the end of their life. Advanced care plans were in also in place which were a record of the preferred actions, interventions and responses that the home and other health care professionals should make following a clinical deterioration or a crisis in the person's condition. This helped to ensure that staff knew the preferences of the people they were caring for and enabled them to be responsive to their needs

We saw care being delivered in line with care plans and peoples wishes, for example one person's care plan said that they like to be assisted to see the hairdresser on Fridays, we saw that this happened. We were aware that another person liked to take their meals in their room watching a particular programme, we saw that this happened. We saw that where people chose to spend time in their rooms, they had their call bells in reach and had access to drinks and snacks.

Where necessary action was taken in response to changes in people's needs. We saw a number of examples where staff had identified that people were unwell and had arranged for the person to be seen by their GP. For example, it had been identified that one person appeared unwell. We saw that the home contacted the GP who reviewed the person and commenced relevant treatment the same day. A relative told us they were always kept informed by the home, they said, "We always get a phone call if [their relative] has needed the doctor". A staff member told us, "We are straight on the phone to the doctor if someone is unwell, or if their skin looks sore then we consult the community nurses".

Staff told us that the shift handovers were a chance to discuss and share how each person had been, including any changes or concerns about their wellbeing. We saw

Requires Improvement

Is the service responsive?

that a falls protocol was in place to respond to falls. Following a fall, a person received increased monitoring. Body maps were completed and shared with the GP so that they could decide if any further intervention was required. This helped to ensure that people received care, treatment and support when they needed it.

People were supported to take part in a programme of activities which were led by the care staff . The programme for the month was displayed on the notice board and we saw that the activities planned for the day of our inspection took place and were enjoyed by a number of people. The service did not employ an activities co-ordinator, so the activities were provided by the care staff and included both individual and group based activities such skittles, puzzles and manicures. We were told that the home had recently purchased a beach hut and had taken a group of residents there for the day which they had greatly enjoyed. The service owns a mini bus which helped to facilitate this trip. For those with specific religious beliefs, the home organised regular visits from the local churches so that people were supported to maintain their faith. Overall, people who lived at The Firs were positive about the activities programme, although one relative told us that they felt there could be more activities. Two health and social care professionals told us that they felt the home would benefit from a more creative programme of activities led by a dedicated member of staff who was able to take the lead in planning a range of activities which people enjoyed and contributed to their on-going physical and mental wellbeing.

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide, including how to raise concerns with the Care Quality Commission. We saw that the annual satisfactions surveys completed with people using the service and with their relatives checked whether they knew how to complain. There had been no formal complaints since our last inspection and where informal comments or concerns had been brought to the attention of the registered manager, we saw they were taking action to investigate these.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the management team. Comments included, "They often come out and say hello….they are always available when you need them." A relative told us, "We can see the management if we need to….our concerns are listened to".

The service had recently introduced a series of audits to measure the quality and safety of care provided. These included audits of medicines records, care plans and aspects of the environment. However It was not always apparent what action had been taken when issues or areas for improvement had been identified. The programme of audit therefore needs to be further embedded before it is an effective tool in assessing the on-going quality and safety of the care provided. The registered manager told us they undertook spot checks which included walking around the home on a daily basis, observing and listening to the delivery of care. We were also told that unannounced spot checks were undertaken at night, although there was no record of these checks or of any actions or developments that were undertaken in response to any issues found.

The registered manager told us they were committed to driving improvements and developing the service. The provider information return (PIR) described how the home was exploring options for a software package to aid responsive care planning. In response to feedback from relatives, the PIR explained how the home was planning an increase in the number of trips and outings available to people. The PIR also described how in response to feedback from staff, additional training was to be sought on effective activities such as gentle exercise. However, we found that there was no service improvement plan in place which detailed the areas they hoped to develop or described the proposed method and resources required for achieving this. Therefore it was not clear what actions the home intended to take to drive continuous improvement and achieve their aim of maintaining the homely approach to people's care.

The registered manager of The Firs had been in post since joining the home in 2008. Before that they had worked as a registered nurse for a number of years and held a recognised qualification in leadership within health and social care settings. They told us that they split their time between The Firs and another home owned by the same provider for which they were also registered manager. The registered manager was supported by a deputy manager who was relatively new in post. The registered manager said they received good support from the registered provider who as a retired general practitioner was able to be very involved in the running of the home and provided the resources they needed to enhance the quality of care delivered to people living at the home.

Arrangements were in place to encourage feedback from people using the service. Meetings were held with people on a regular basis. The minutes of the most recent meeting showed that issues discussed included the food and activities. We saw that people said they had enjoyed the baking activities and would like more opportunities to do this. The deputy manager told us that in response to this, the service had made arrangements for additional baking activities to take place and planned to incorporate this into some themed Halloween events which we saw were scheduled for later in October. The deputy manager also told us how the service was implementing changes to the menu based on the feedback from people using the service. This showed that people were listened to and their views were taken into account when shaping the service.

Staff were well supported to carry out their roles. Each shift was led by a senior staff member who was supported by the deputy manager or registered manager except at weekends when the head staff member provided management support. Staff were positive about the leadership of the home. They told us that the management team had a good presence within the home, they all agreed that there was a culture of openness and fairness and that moral amongst the staff team was good. One staff member said, "The manager is by far the best manager I have ever had, as is the deputy, they know what's going on, you can go to either of them and voice your opinion, they take it on board and act on it". Another staff member told us that that the management team were "both brilliant" she explained that the registered manager had come in at 4am to support them when someone had passed away in the night which they had found extremely reassuring and supportive.

Handover meetings took place daily and were an opportunity to review people's health and wellbeing. This helped to ensure that there was effective monitoring of people's needs within the home. In addition there were regular management meetings with the senior team. We saw records of these meetings and saw that these were an

Requires Improvement

Is the service well-led?

opportunity to discuss issues affecting people using the service, practice developments and to guide and support the deputy manager in their role and responsibilities. Meetings were also held with the whole staff group. Staff were encouraged to ask questions or offer comments or suggestions. This helped to ensure that the engagement and involvement of staff was promoted within the home. These meetings also helped to ensure that the registered manager remained informed about day to day issues within the home.

Staff had opportunities to continuously learn and develop. We saw that the staff notice board contained information about updates to best practice in the sector and amendments to policies and procedures. Staff told us, "If I need training it is always available, we get the utmost support". Staff told us they were supported to access additional qualifications. For example one senior carer was about to start a leadership and management qualification. We saw that staff had job descriptions and information about their key responsibilities. The registered manager told us that staff were given clear guidelines on how to deliver care which helped to ensure they were clear about what was expected of them.

People who used the service had completed a satisfaction survey May 2014. The majority of the responses showed that people were happy with the care and support they received. Comments included, "more than happy…thanks for all you do". The registered manager told us they had spoken with people or their relatives in response to any issues raised, although they had not maintained a record of this.

Management and staff spoke openly with us about the key challenges facing the service which included fully implementing the requirements of the MCA and DOLS and maintaining a stable staff team whilst managing the increased number of people accessing the service for respite.

The registered manager told us that they were proud of the care provided and of close knit team and how well the staff work together. A staff member told us, "I love working at the home, I have worked in care for 20 years and feel that this home is the best…. all the residents seem happy…it's a lovely friendly home".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not being fully protected against the risks associated with the unsafe use and management of medicines because the registered person had not made appropriate arrangements for the storage, recording and disposal of medicines. Regulation 13.