Caldwell Care Limited

The Firs

Inspection report

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Locks Heath
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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 16 and 17 August 2016.

The Firs provides accommodation for up to 22 older people who are physically frail or may be living with mild to moderate dementia. At the time of our inspection there were 20 people living at the home. The home provides long term care and respite care. It does not provide nursing care. Most people needed some assistance with managing daily routines such as personal care. A small number of people needed support with eating and drinking 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 is a secure garden to the rear of the property. The accommodation is arranged over two floors with both a lift and stairs available for accessing the first floor. The home offers 16 single rooms and three shared rooms. All of the rooms have ensuite 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 and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was also registered manager for one of the provider's other services.

The registered manager had not always submitted statutory notifications on time. Staff recruitment checks needed to be more robust.

Staff displayed a commitment to protect people from harm and to protect them from abuse. However, we found that the registered manager had not appropriately escalated a potential safeguarding concern to the local authority safeguarding teams.

Improvements were needed to ensure that all of the risks to people's wellbeing and those associated with the environment were effectively assessment and managed.

Audits needed to be more robust to ensure they were driving improvements.

There were sufficient numbers of staff deployed to meet people's needs. Supervision had not been taking place regularly, although we saw that this was an improving picture. Further improvements are planned to extend the training programme which staff felt was adequate and helped them to provide effective care.

Action was being taken to embed the principles of the Mental Capacity Act 2005 within the care planning process. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations had been applied for.

People's medicines were managed safely.

People told us they enjoyed the food provided and staff were informed about whether people were nutritionally at risk.

The home worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support.

People were treated with dignity and respect. Staff were kind and caring in their interactions with people and had developed positive relationships with people. People took part in a range of activities which they enjoyed.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide and displayed within the home.

Everyone spoke positively about the friendly atmosphere within the home. There was a positive culture with staff working well as a team to meet people's needs effectively.

People and staff could make suggestions about how the service might improve and the provider acted upon these.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of this report.

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

Staff recruitment checks needed to be more robust.

The register manager had not appropriately escalated a potential safeguarding concern to the local authority safeguarding teams.

Improvements were needed to ensure that all of the risks to people's wellbeing and those associated with the environment were effectively assessment and managed.

There were sufficient numbers of staff to meet people's needs safely and people's medicines were managed safely.

Is the service effective?

Good

The service was effective

Improvements were underway to help ensure that staff received regular supervision. The training programme for staff was being extended to ensure it enabled them to meet the needs of people effectively.

Action was being taken to embed the principles of the Mental Capacity Act 2005 within the care planning process. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations had been applied for.

People told us they enjoyed the food provided and staff were informed about whether people were nutritionally at risk. Staff worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff were kind

and caring in their interactions with people. Staff had developed positive relationships with people.

Is the service responsive?

Good

The service was responsive.

Records were written in a manner that helped to make sure people received care that was centred on them as an individual.

People took part in a range of activities which they enjoyed.

People knew how to make a complaint and information about the complaints procedure was displayed within the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had not always submitted statutory notifications on time. Audits needed to be more robust to ensure they were driving improvements.

Everyone spoke positively about the friendly atmosphere within the home. There was a positive culture with staff working well as a team to meet people's needs effectively.

People and staff could make suggestions about how the service might improve and the provider acted upon these.

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 took place on 16 and 17 August 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection we reviewed all of the information we held about the service. This included previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is where the registered provider tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with ten people who used the service and four relatives. We also spoke with the registered provider, the registered manager, deputy manager, head of care and two care workers. We reviewed the care records of four people in detail and the recruitment records for four staff. We also reviewed the medicines administration record (MAR) for seven people. Other records relating to the management of the service such as staff rotas, training records and policies and procedures were also viewed. Following the inspection, we sought the views of six health and social care professionals about the home and the quality of care people received.

The last full inspection of this service was in October 2014. At that time the service was rated as 'Requires Improvement'. We found that the provider had breached the Regulations in relation to how medicines were managed. When we visited in May 2015, we found that medicines were still not being managed safely so we served a warning notice requiring the provider to make the necessary improvements. We returned again in August 2015 and found the improvements had been made and medicines were now being managed safely.

Requires Improvement

Is the service safe?

Our findings

Each of the people we spoke with told us they felt safe living at The Firs. A relative told us, "I feel [their relative] is very safe, she has an alarm and they also got her mat to use at night-time so that they know if she gets up".

Whilst people told us they felt safe, we found that some improvements were needed. Recruitment checks needed to be more robust and include all of the requirements laid out in the Regulations to ensure only people suitable to work within an adult social care setting were employed. For example, in the case of three care workers, we were not able to see that the provider had obtained a full employment history. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Employed.

Other relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks.

Staff had received training in safeguarding adults, and displayed a commitment to protect people from harm and to protect them from abuse. The provider had a robust policy in place which described the procedures and processes in place to safeguard people from harm. However, when we reviewed the complaints received by the service, we found that one of these raised potential safeguarding concerns, but these had not been escalated to the local authority safeguarding teams. The registered manager had undertaken an internal investigation which had resulted in the opportunity for organisational learning but consideration had not been given as to whether the concern might warrant a referral to the Disclosure and Barring Service (DBS).

The failure to report these concerns and follow systems and procedures to keep people safe was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . Safeguarding service users from abuse and improper treatment.

Following the inspection we spoke with the Local authority about the incident. They advised that they would be in touch with the service and support them with developing their understanding of safeguarding procedures.

Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the registered manager of the home. One care worker said, "I am so confident [the registered manager] would act". They were also aware of other organisations with which they could share concerns about poor practice or abuse.

Whilst there were some health and safety checks taking place, further improvements were needed to ensure that all of the risks associated with the environment were effectively addressed. The provider was not able to demonstrate that the actions identified at a fire risk assessment undertaken in October 2014 had been completed. The provider told us that they would arrange for an immediate update to the fire risk

assessment and complete any required actions. We will check to see that this has been done. Some checks were taking place to ensure that people were not at risk of scalds or burns from the hot water being discharged from the bath and showers within the service. However, similar checks were not being made to ensure that the water being discharged from the sinks in people's rooms was within safe limits. There was no risk assessment of the hot and cold water systems to ensure adequate measures were in place to control Legionella. Legionella bacteria are commonly found in water and can lead to people developing Legionnaires disease which can be particularly harmful to older persons.

Vulnerable people can be at risk of falling from windows in settings such as care homes. There were no risk assessments regarding this and whilst there were window restrictors in place, these were not sufficiently robust. There was no risk assessment in place to identify any potential risks from people using or accessing the stairs. We spoke with the provider about this. They told us they would ensure relevant risk assessments were completed as a matter of urgency. However the failure to ensure that all aspects of the premises were safe and risks associated with the environment were adequately assessed and managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

The provider had developed a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. Regular checks were made of the call bell system. Monthly checks were undertaken of the fire equipment. Checks were also undertaken to ensure the safety of electrical equipment.

Improvements were needed to ensure that all of the risks to people's wellbeing were assessed and planned for. People at risk of leaving the service, without staff being aware, did not have a risk assessment or care plan regarding this. Some risk assessments contained conflicting information to the corresponding support plan. For example, one person's moving and handling risk assessment stated that they required a medium sling. Their mobility plan stated this should be a small sling. Tools used to assess a person's risk of developing skin damage were not always being completed correctly. This limited their effectiveness as a risk assessment tool. Another person's choking risk assessment did not reflect their current needs. Their nutrition plan was not explicit about their dietary requirements. For example it said, 'Thickener prescribed for all drinks'. It did not say to what consistency. Most of the staff we spoke with were clear about the correct dietary guidance for this person, although one care worker seemed less clear and indicated that they thickened the drinks in line with the person's preference as they disliked the thickener. The failure to ensure that all the risks to people's safety and wellbeing were fully assessed and managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Other risks to people were well managed. Systems were in place to help manage and respond to the risks associated with falls. People had falls risk assessments. Records showed that following a fall, staff followed a protocol which involved staff completing a body map and monitoring the person for 24 hours and updating the person's doctor. Staff had arranged for one person who was experiencing regular falls to have a pendant alarm, which they could wear at all times allowing them to alert staff to the fact that they needed help. Staff were also due to attend falls prevention training, the week following our inspection. A heath care professional told us staff appropriately sought and acted upon the advice of occupational therapists and physiotherapists. They said they were happy the home was working with them to reduce the prevalence of falls.

People had choking risk assessments and moving and handling risk assessments. Nutritional risks were

monitored. When a person was first admitted to the home, for a period of six weeks, their food and fluid intake was monitored closely, this gave staff a reference point and helped them to judge whether the person might require additional nutritional support. Each person was weighed on a regular basis to monitor whether they might be losing weight. Where weight loss was identified as a concern, a letter was sent to the GP to advise of this and food and fluid charts were commenced to monitor this. The food and fluid charts viewed were detailed but we did note that staff were not totalling the fluid charts on a daily basis. This is important as it helps staff to assess whether people are taking in the recommended fluid level and take remedial action where needed.

We looked at the arrangements for keeping the service clean and for the prevention and control of infections. Overall we found that the standard of cleanliness in the home was good. A housekeeper was employed for five days a week and records were maintained to show that the cleaning schedules including those for deep cleans were followed. People and their relatives described the home as "Spotless" and "Really Clean". Protective clothing, including gloves and aprons, were available and were used by staff appropriately. We did find that some areas of the kitchen could be cleaner. There was food debris on the floor and cupboard handles felt sticky. Some of the cupboard doors had lost their outer coating which would make them difficult to clean and could present an infection control risk. These are areas which need to improve. We checked the fridge and found that food was being stored safely and in line with guidance from the Food Standards Agency. Temperatures were being taken daily of the fridge and freezer to ensure that foods were being stored at safe temperatures.

People told us there were sufficient staff to meet their needs. One person said, "I can always have a shower when I want one". Another person said, "There are always enough staff for my needs". A relative told us there always appeared to be enough staff available to support their mother. Our observations indicated that people's needs were being met promptly.

Between 7am and 8pm there were three care workers available to support people one of whom was a senior care worker and responsible for managing people's medicines. During night shifts there were two care staff on duty. The registered manager told us these target staffing levels were based upon the dependency needs of the people using the service, although they did not currently use a systematic approach to determine this. They said, "I am hands on, I know if people's needs have increased, if so I would increase staffing levels". They explained the registered provider was very supportive of any requests for additional staffing.

We recommend that the registered manager use a systematic approach to determining whether the numbers of staff deployed is sufficient to meet people's needs.

We reviewed the staffing rotas for a four week period and found that the service had been staffed to the levels described above. The rotas showed that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them well. A number of ancillary staff were also employed including a cook, housekeeper and a maintenance person who also worked at the provider's other service.

Staff told us that the staffing levels were adequate and enabled them to perform their role and responsibilities. One staff member said, "There are always enough staff to meet people's needs, sometimes, if it's a busy day we may neglect the laundry, but people are cared for". Staff told us that staffing levels remained consistent at weekends and meant that at all times people were able to make choices about when they got up or went to bed. One care worker said "The deputy manager is always happy to help if we are busy".

There were policies and procedures in place to ensure the safe handling and administration of medicines. Medicines were administered by staff that had been trained to do this and arrangements were in place to ensure staff had an annual review of their skills, knowledge and competency to continue to administer medicines safely. People had a medicines care plan which included information about how they liked to take their medicines and risks associated with not taking these correctly. For example, one person had clear guidance in place about the need for their Parkinson's medicines to be administered at exactly the right time. Each person had a medicines administration record (MAR). We reviewed seven people's MARs. These contained sufficient information to ensure the safe administration of medicines including a photograph, their date of birth and information about allergies they might have. The MARs checked contained no gaps. Handwritten MARs were completed by two staff. Where people were prescribed topical creams, people had topical medicines administration records (TMARs) which were clear and mostly fully completed. Where people were prescribed 'as required' or PRN medicine, information was available to explain how and when the medicine should be used. Protocols were also in place for the use of variable dose medicines. Medicines were stored safely in a locked medicines trolley which was stored in a medicines room. Room temperatures were being taken daily to ensure the medicines were being stored within recommended temperature ranges. Controlled drugs (CD's) were stored and managed safely. We checked the balance of two such medicines held in the cabinet against the CD register and found that they tallied. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused. Staff were able to describe clearly the actions they would take in the event of a medicines error.

Good

Is the service effective?

Our findings

People, their relatives and healthcare professionals told us The Firs provided effective care. A relative told us, "There is nothing they could do better, I am happy with everything". Another said, "I'm very impressed". A healthcare professional told us staff appeared well trained, with the right skills and knowledge. They said, the head of care had a "Level of knowledge above the average carer". They told us they would "Have no qualms about a relative living at the home….it's one of the homes I like the most".

The Mental Capacity Act (MCA) 2005 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. It was clear that staff considered a person's capacity to make decisions as part of the care planning process. People had a 'Rights, Consent and Capacity' support plan. The need to act in accordance with people's consent and choices was clearly referenced throughout this plan. Most of the people using the service were able to make their own decisions about how their care and support should be provided. Where this was the case, they told us that staff respected their decisions and choices. We observed staff ask, "Would you like help cutting up your meat?" and "Can I pour you some more drink?". Some people had appointed a personal attorney to make decisions about their health and welfare on their behalf. Where this was the case, staff had retained a copy of the Lasting Power of Attorney (LPA). This helped to ensure staff could be confident that the attorney was authorised to make relevant decisions and therefore needed to be consulted about the person's care and support needs.

We did note that some the information regarding how people made decisions and the help they might need with this was a little confusing or at times inconsistent. For example, one person's care plan said they had 'mental capacity to make decisions at all times'. The plan went on to say that their care would be provided in their best interests. This would not be in keeping with the principles of the MCA 2005. Another person's care plan contained a consent form for the use of bed rails. This had been signed by the person's relative. We were told that the person had capacity to make this decision; therefore the consent form should have reflected this and should not have been signed by a relative. The registered manager was aware that this was an area where improvements could be made. They showed us that they were planning to use the Local Authority's mental capacity toolkit to help ensure that they and staff were able to fully document the mental capacity assessments undertaken. With support from local authority staff one assessment had already been completed regarding the use of bed rails for a person. This was suitably detailed and documented appropriately. This process once embedded will help to ensure that the staff are acting in accordance with all of the requirements of the Mental Capacity Act 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring 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. Relevant applications for a DoLS had been submitted by the home and were in the process of being assessed by the local authority.

Staff had completed training in a range of subjects such as moving and handling, infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding and health and safety. Two staff had recently undertaken training in supporting people to undertake exercise aimed at improving their flexibility and balance. We did note that only a small number of staff had completed training in caring for people living with dementia. Some of the people using the service were living with dementia, some could also at times display behaviour which could challenge others, yet not all care workers had received training in these areas. The registered manager told us that training in these areas would in the future be mandatory for all staff to complete on annual basis. They told us that this would be in place by September 2016. All of the staff we spoke with said that the training provided was adequate to enable them to perform their role effectively and the health and social care professionals we spoke with did not express any concerns about the skills and knowledge of the staff team.

Supervision had previously not been taking place on a regular basis. Supervision is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. We noted for example, that a senior staff member who was often responsible for leading shifts in the absence of the registered manager or deputy manager had not had any supervision since December 2015. The registered manager felt that the frequency of supervision was an area where improvements were being made and the records did show an improving picture. They also explained that there were weekly managers meetings where they were able to meet with their senior staff to discuss any issues or concerns. All of the staff we spoke with felt well supported in their roles and were confident they could approach the registered manager or deputy manager at any time with any concerns or issues they might have. Most staff had taken part in a recent appraisal of their practice.

Systems were in place for new staff to have an induction which involved completing some essential training and becoming acquainted with the environment and people using the service. New staff were also required to complete a competency based induction in line with the nationally recognised Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate and should be completed as part of the new workers induction. We did note that some new staff had not completed their induction programme within the timescales determined by the service. The registered manager was aware that this was an area that needed some attention and advised that the provider's quality and compliance manager would be focusing on this to ensure that the Care Certificate was implemented more effectively within the service.

People were positive about the food and comments included; "The food is good, no complaints"
A relative said, "The food is good, there is enough choice, they love the puddings, their appetite has improved, they get lots of drinks and yoghurt every afternoon". A health care professional told us, "The food smells lovely" and another said, "The food is excellent, there are always freshly baked cakes and cookies".

There was a four week varied menu with two choices available each lunch time. People were able to comment on the quality and variety of food provided and their views were listened to. For example, we saw that in a residents meeting in April 2016 they had requested more fresh vegetables be used. By the meeting in June 2016, people were commented that this was now in place. Information was available about people's preferred foods and their likes and dislikes were catered for. For example, one person was a vegetarian and had expressed a wish for some of their foods to be ordered from a particular shop and to be cooked in a certain way. In response, a grill had been purchased and the special items requested had been provided. Where people had lost over a certain amount of weight, we saw that staff referred them to the GP for a review. We observed the lunch time meal. People could choose where to eat their meal but most sat in the dining area at tables which were laid with cloths, napkins and flower displays. Plate guards and specialist drinking cups were available and used when necessary to support people's independence with eating their

meal. Staff were well informed about people's dietary requirements and we observed that people were provided with a meal that was in line with these. We observed staff helping one person to eat their meal; they gently stroked their face to wake them and then supported them to eat in a kind and attentive manner. When one person's meal became cold, staff reheated this before continuing to support the person.

Where necessary a range of healthcare professionals including GP's and community mental health nurses had been involved in supporting people to maintain good health. A relative told us, "[the person] gets lots of urine infections, but the doctor is called quickly". A record was maintained of the outcome of visits from doctors or community nurses and where verbal changes were made to, for example, people's medicines, staff ensured this was confirmed in writing. This helped to ensure that people received co-ordinated care, effective treatment and support.

Good

Is the service caring?

Our findings

People told us they were supported by staff who were kind and caring. Their comments included, "They are very attentive….all kind and caring, never a cross word, they are very patient". Another said, "They are all very kind, if I was going to stay somewhere like this long term, here would be fine". Staff were positive about the caring nature of their colleagues. One care worker said, "Yes they are all kind and caring or I would tell the manager". A health care professional told us, "Staff have always been very friendly and helpful and I have witnessed nurturing, caring staff and positive interactions with their residents".

Staff, including the housekeeping team had good relationships with people and chatted with them about every day matters such as the food or the news. They spoke with people kindly, respectfully and cheerfully. People told us they had developed good relationships with the staff who they felt knew their needs well. A relative said, "[Their relative] gets lots of attention, staff come and sit and do their nails, they know all about the workers and their families". Staff were sensitive to people's needs. We saw staff gently wake one person to offer them their lunch. They encouraged the person to eat by joking, "Go on you eat it before I do". When the person indicated they could not face the meal, the staff member offered a replacement and brought the person a selection of sandwiches. Throughout the inspection we observed that staff were patient and did not hurry people, but completed tasks slowly and in a person centred manner.

People's relatives and friends were able to visit without restrictions, and we observed relatives visiting throughout the day and sharing in aspects of their loved ones care, but also interacting with other people using the service too. A relative told us, "Yes I feel welcome".

People were encouraged to remain in control of decisions regarding their care. The registered manager told us they had spent time with one person, fully exploring and discussing the pros and cons of the use of bed rails. The person had capacity to make this decision and so their choice to not have bed rails in place was being respected even though this presented some degree of risk for the person. In another example, a person had expressed a wish for some of their medicines to be kept in their room and not in the medicines trolley. Arrangements had been made to facilitate this.

Staff were mindful of people's privacy and dignity. They spoke with people in a polite and respectful manner. They described how they ensured doors were shut when personal care was being provided. There were three shared rooms at The Firs; staff told us that in these rooms they ensured that privacy screens were used to protect people's privacy. A visitor told us their relative was always nicely dressed which they felt was important and helped to maintain their dignity. Minutes of a staff meeting showed that staff had raised the issue of ensuring people's clothes were treated with respect as this was important to people.

People were supported to follow their spiritual needs. A vicar visited the service to lead prayers and hymns with people in groups or as an individual. Other people were supported by their families to visits churches within the local community. People had an end of life care plan. Some of these were more detailed than others, but we saw some which were very person centred. They had clearly been drafted with the person and their relatives and described the person's wishes in relation to how they would like their care and

environment to be managed in their final days. The plans demonstrated that staff understood the importance of helping people to have dignified and pain free end of life care.

Good

Is the service responsive?

Our findings

People and their relatives told us they received care that was responsive to their needs and wants. All of the relatives we spoke with felt they were kept informed about their relative's care and that their views and ideas were valued and acted upon. One relative said, "We are very happy, they put a new TV in for [their relative]". Health and social care professionals were also complimentary about how responsive the service was. A health care professional said, "They are very good at calling us in".

People were cared for by staff who knew their needs and individual personalities. Care plans we viewed were written in a manner that helped to make sure people received care that was centred on them as an individual and met their needs, choices and preferences. For example, one plan described how the person was 'Intellectual and chatty'. Plans described people's likes and dislikes including how people liked to dress and their preferred foods. One plan described how a person had a 'Passion for cake'; the person told us they were offered "Lovely" cakes on a regular basis.

Care plans contained information about people's preferred daily routines and where they preferred to eat their meals or how they liked to take their medicines. The person or their relatives were asked to provide information about the person's life before coming to The Firs and care plans contained a detailed life history. It was evident that staff had read this information and used it to help ensure they provided responsive care. For example, they were able to tell us about one person's favourite breakfast and preferred snacks and how another person had once been a diver and really liked talking about their life at sea. The service had received a recent compliment which read, 'Thanks for all your kindness and excellent care, you all got to know [the person] and her little ways'.

Some areas of people's care plans could be more detailed. For example, one person could at times display behaviours which others might find challenging but they did not have a detailed care plan which described how staff should respond to this. Distress Monitoring Charts were used to record any incidents and we were able to see that staff were working with the community mental health team to review the person's medicines. However, when we asked staff how they responded and supported this person when they displayed behaviour which might challenge others, each staff member described a slightly different approach. A detailed care plan would help to ensure that staff provide a consistent response and are all well informed about how to de-escalate behaviours which might challenge others.

Each person had a key worker who was responsible for updating care plans and for undertaking the monthly evaluations. They were also primarily responsible for keeping relatives informed of any changes to a person's wellbeing. One relative told us, "The least little thing they phone me". Handover meetings were conducted daily during which staff shared information about any new risks or concerns about a person's health. Daily records were completed to show the care each person had received. Where required, food and fluid charts and turning charts were used to document and monitor aspects of people's support. The registered manager told us there were plans to introduce an electronic care planning system with staff using electronic devices to access care plans and record the support provided. It was hoped that this would support staff to complete records in a timely manner without this detracting from the care people received.

People took part in a range of activities. All of the people and relatives we spoke with were positive about the quality and quantity of the activities. A relative said, "They had a singer last Thursday and they also do bingo and I spy". Whilst there were no designated activities staff, the care staff were able to spend time leading a variety of activities and a range of outside entertainers also visited the home such as an animal farm and an accordion player. The registered manager told us that one person cared for in bed, really enjoyed being visited by the owls brought along by one entertainer. Other activities available included painting, baking, gardening, skittles and table tennis. The provider owned a beach hut and during the summer months, staff used the service's mini bus to take people on day trips to the hut before enjoying fish and chips on the beach. A health care professional told us, "They really try and engage the residents in activities such as baking; there is always a good atmosphere". Following suitable checks, volunteers were welcomed within the service to spend time with people and lead activities. The registered manager advised that they hoped to extend this role.

People knew how to complain and information about the complaints procedure was available within the home. People and relatives were confident they could raise concerns or complaints and these would be dealt with. When complaints had been made these had been investigated and a record was maintained and the outcome of the complaint was recorded

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been leading the service for just over a year when we inspected. People, their relatives and the staff team were positive about their management of the home. One relative told us the registered manager 'listened' to what they had to say and 'sorted things out' if there were any problems. Staff said the manager was approachable and supportive. One staff member said, "They occasionally work on the floor, it's better that way, they see reality, they are always willing to help". Another staff member said, [The registered manager] is always available when we need her". A health care professional said of the registered manager "She has gone out of her way on a couple of occasions to ensure she accommodates the needs of our clients, safely and securely… She is very knowledgeable and in two cases, where I have worked with her, the clients needed short term respite care to enable them to return home. [The registered manager] ensured she and her staff could not only look after the needs of my ladies at that time but help them progress and become stronger enabling them to return home".

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when a person suffers a serious injury. We found from reviewing the accident and incident records that two people had suffered serious injuries but the CQC had not been notified in a timely manner. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

Some audits were being undertaken to monitor the effectiveness of aspects of the service. Care plan audits were completed. Where previous audits had highlighted areas which needed to be addressed, checks were made to see that these had been completed. A very detailed medicines audit was completed on a regular basis and included a record of the actions or changes necessary as a result of the audit findings. The actions viewed had been completed. Accident and incidents were reviewed so that trends or themes could be identified, allowing remedial actions to be taken. Relatives undertook cleanliness audits from time to time and people were involved in food quality audits. We did note that the audit programme had not identified the areas where this inspection found improvements were required. This would indicate that the audit programme needs to be more robust. We also noted that there was no service improvement plan in place. These plans identify the areas which registered managers and providers plan to develop and improve. They explain how they will achieve this and the resources needed to do so. The plans help to drive continuous improvement

People and their families were asked to give their views and feedback about the care and support they received. Resident meetings were held and it was clear from minutes of meetings that their views were valued and acted upon. For example, we saw that at a recent resident's meeting, people had asked for new place mats. These had been ordered. They had asked for different prizes to be available for the games in the afternoon. Again this had been actioned. Resident meetings were also used to discuss the food and staffing issues and the activities people would like to do. A relatives meeting was due to take place the week following our inspection. They had been invited to add anything they would like to discuss to the agenda for the meeting. One relative told us he felt his views were listened to, he said, "At a meeting, I brought up an issue….they are going to do something about it". Satisfaction surveys were undertaken with the responses

seen being positive about the service. For example, one person had written, 'Grateful for the care….the friendly, kind, caring and humorous staff, willing to go the extra mile'. The registered manager told us that if surveys identified areas for improvement, these would be formulated into an action plan.

Staff meetings were held and staff were encouraged to contribute their ideas and make comments or suggestions about how the service might improve. It was evident that wherever possible the requests or suggestions of staff were met, for example, new irons, funding for trips out and adjustments to the staff rota and the timing of meetings. Meetings were attended by the provider and it was evident that they were supportive of the registered manager and staff team and committed to driving improvements within the service. For example, we saw that they were happy to resource staff taking people out to activities of their choice such as for a coffee or to the theatre.

The registered manager praised her staff team. They said, "I have really good motivated staff, I can trust them, we have built a good relationship, they are a good team, they keep me informed and respect me as a manager… we work well together, share ideas, there is a good atmosphere". Morale amongst the staff team was good. One care worker said, "Yes moral is good, we work hard and work as a team". Another said, "Team work is really good, no-one likes letting anyone down, it's like The Firs family". Another staff member told us how they had worked in three care homes, they said, "But this one is the best". The registered manager told us it was important to her that "Every person should enjoy every single day" and we observed throughout our inspection that staff were committed to providing a high standard of person centred care and support.

The registered manager had a good understanding of the challenges facing the service, which included making sure they had sufficient time to spend within each of their services to monitor the quality of care and to drive continuous improvements. They were positive that the introduction of the electronic care planning system would increase their ability to have prompt oversight of care delivery across both of the services they managed. Throughout this inspection the registered manager and provider remained open to receiving feedback. Where the inspection identified areas where improvements or actions could be made, where able these were acted upon promptly or provided reassurances that action would be taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always ensured that CQC were notified when people suffered serious injuries.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that all of the risks to people's safety and wellbeing were fully assessed and managed and that aspects of the premises were safe and risks associated with the environment were adequately planned for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that potential safeguarding concerns had been escalated to the local authority safeguarding teams.