Abbeyfield Society (The)

The Firs Nursing Home

Inspection report

700 Mansfield Road
Sherwood
Nottingham
Nottinghamshire
NG5 3FS

Tel: 01159531123
Website: www.abbeyfield.com

Date of inspection visit:
26 September 2017

Date of publication:
06 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 26 September 2017. The Firs Nursing Home is a purpose built care home. They are registered as a care home with nursing and provide accommodation for up to 31 older people. The service offers accommodation over three floors, with a lift to access the first and second floor. On the day of our inspection 30 people were using the service.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks in relation to people developing a pressure ulcer or who had a wound were not always assessed or monitored appropriately. People's needs were not always met in a timely way due to the way staff were deployed in the service.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. Medicines were managed safely and people received their medicines as prescribed.

People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions and staff knew how to act if people did not have the capacity to make decisions.

People were supported to maintain their nutrition and staff responded to people's changing health and sought advice and guidance from health and social care professionals.

People were not always supported in a caring and compassionate way and their dignity was not always upheld. People who lived with a dementia related illness were supported by staff when they became distressed and staff respected people's rights to privacy.

The systems in place to monitor the quality of the service were not always robust in identifying where improvements needed to be made. People were involved in giving their views on how the service was run. The management team were approachable and supportive.

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 consistently safe.

People's needs were not always met in a timely way due to the way staff were deployed in the service to provide care and support to people when they needed it. Risks in relation to the prevention and management of pressure ulcers and wounds were not always assessed or monitored appropriately.

The risk of people being abused was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as prescribed and medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who received appropriate training and supervision.

People made decisions in relation to their care and support and where they needed support to make decisions they were protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and changes to their health was responded to appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported in a caring and compassionate way and their dignity was not always upheld.

.

People who lived with a dementia related illness were supported by staff when they became distressed.

Staff respected people's rights to privacy.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support and were supported to have a social life and to follow their interests.

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to monitor the quality of the service were not always robust in identifying where improvements needed to be made.

People were involved in giving their views on how the service was run.

The management team were approachable and supportive.

The Firs Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 comprehensive inspection was carried out on the 26 September 2017 by two inspectors, a specialist advisor, who was a nurse, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care 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 also reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During the inspection we spoke with 10 people living at the home, seven visitors and relatives, a member of the catering staff, the activity co-ordinator, and three members of the care staff, a nurse, the deputy manager and the registered manager.

We looked at care records relating to seven people living at the home and the medicines records for 10 people. We reviewed other records relevant to the running of the service such as, staff recruitment records, quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

During the inspection we spoke with three health and social care professionals who gave us their views on the quality of the service provided.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff appropriately deployed in the service to meet the needs of people. People who used the service and their relatives commented on having to wait for staff to support them when they requested it. One person told us, "They (staff) don't necessarily come that quickly; it just depends on those around. Sometimes they are hard pressed for time and explain they can't do things but will do it later." One relative said, "You should be here on a Sunday. There's only one adult (staff member) in the dining room with them and they (residents) are told to wait."

Another relative told us, "The morning drinks get later and later, sometimes comes at quarter to twelve and [relation] is getting fidgety." A third told us, "On a day to day basis there are not enough staff to cater for individual needs. I appreciate some people are challenging and demanding but I'm not convinced they are always catered for. Those that need to go to the toilet have to wait a long time, I have seen staff telling people to wait so I've intervened, it's not fair." A fourth relative told us,"I don't think that they can all get up and go to bed when they want, it's a staffing issue. I don't think they (residents) have a great deal of choice in that." The relative asked their relation if they did have a choice in relation to this and they responded, "No."

We observed the lunch period and saw that there was a long wait from people being supported to go to the dining room to the time they were given their lunch. Staff started to take people into the dining room and at 12.30pm there were 13 people in the dining room at 1pm but only one person had been served a meal. Other people were then given their meal but a number of people had been seated in the dining room for 40 minutes by the time they were given anything to eat.

During our lunch observations there were periods of time when there were up to six people in the dining room with no staff present. We also observed prior to the evening meal that people were in the dining room, some in wheelchairs and there were no staff present as they were busy getting other people ready for their meal. One person in a wheelchair was trying to get out of it and the brakes were not secure. We asked a member of staff to address this and they asked another member of staff to observe the people in the dining room.

We observed one person who needed support to eat their meal at lunch time did not receive support until their meal had been in front of them for a period of fifteen minutes. We observed another person during the morning who had a hot drink left with them but needed support to drink it. We observed the drink was there for some time and it was nearly cold. A member of staff eventually went to support the person after being prompted by the deputy manager.

We observed that one person was calling out for assistance to get out of bed and had activated their nurse call buzzer. This person was clearly distressed and we sat with them to offer reassurance. After a period of five minutes a member of staff arrived and informed the person that they had called for additional staff to assist them. We noted that this staff member was required to leave the person they were initially supporting, to respond to this person. We recorded a period of 21 minutes passed before the additional staff were available to offer assistance to this person. During this time the person became more distressed and

although the initial member of staff had stayed with them, they struggled to calm the person and this also meant they had left the person they were initially supporting for a period of 21 minutes.

We noted that since we last inspected people's needs were more complex as they were growing older. We observed staff were very busy throughout the day with call bells ringing frequently. At one point there were three people who had pressed their call bells simultaneously. We observed it was seven minutes before staff got to one person who had called for assistance. Two people who lived with a dementia related illness needed a lot of staff support throughout the day due to their illness causing them distress. One member of staff we spoke with confirmed that people now needed a higher level of support. We spoke with the deputy manager about how staffing levels were assessed and they told us a tool was not used to determine staffing levels but that there was a set number of staff budgeted for and any requests for additional staff would go to the registered provider. This meant we could not be assured that staffing levels were routinely reviewed to ensure they were sufficient to meet people's changing needs.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks in relation to people's health care were not always monitored appropriately. Where people were at risk of developing a pressure ulcer this was regularly assessed to minimise the risk of a pressure ulcer developing. However where people developed a pressure ulcer the risks of this getting worse was not monitored effectively. One person had a significant wound on their leg and there were several photographs of the wound in the person's records, which had been taken in July 2017. The wound had initially been assessed in July 2017 by an external health professional and a dressing regime prescribed. The external health professional had stated that no further input was required from them as the nursing staff at the service could monitor and manage the wound.

There was a care plan in place, but the current regime for wound management remained as per the instructions from the external health professional and there was no recent evidence documented as to whether the wound was healing at the time we inspected the service. The only updates to the nursing care were entries stating when the dressings were changed. This meant there was a lack of assessment as an indicator of progress or deterioration in the wound. Another person's records showed they had been found to have blisters on their skin in August 2017. There was no further records to show how the blisters had been cared for or if they had healed, other than a further record in September detailing the person had a water filled blister and again nothing documented as to the healing process.

Records showed that two people were at risk in relation to another health condition and needed to have their bowels monitored. Records of one of these people showed that the bowel charts had not been completed since February 2017. There were frequent gaps in the charts for the other person of up to 10 days and the care plan did not give staff guidance on what the person's usual pattern was or action to take if the person did not open their bowels.

We found that the frequency of re-assessing people's risks were not always adhered to. Risks were supposed to be assessed monthly but we found this was not always happening. For example, one person had a moving and handling risk assessment in place and although the assessment stated that frequency of re-assessment should be monthly, this had not been assessed for over a year. Another person had been assessed as being at high risk of developing a pressure ulcer and the monthly assessment had not been carried out in the four months prior to our inspection.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People received care and support from a staff team who knew how to protect them from experiencing avoidable abuse and harm. People told us that they felt safe in the service and relatives said they felt the service was a safe environment for their family members. One person whose bedroom was on the top floor told us they preferred to spend most of their time in their bedroom and said, "I feel safe, yes. They have qualified nurses and they always pop in. Sometimes if I'm awake at night I see the door crack open and they check on me. There's always someone around up here." A visiting relative told us they felt their relation was safe and said, "They've got all the gadgets in [relation's] room, pressure pads, alarms."

Systems were in place to reduce the risk of people experiencing avoidable harm or abuse. Staff spoke knowledgably and confidently about what they would do if they thought people were at risk of harm and we saw they had been given training in relation to this. There was also a dedicated hotline for staff to use to report concerns higher in the organisation if needed to. Records showed the registered manager had made referrals to the appropriate authorities where needed.

The risks to people's safety had been assessed and plans put in place to minimise the risks. Where risks were identified there were measures taken to reduce the risk. For example, one person who had started to fall when mobilising had been referred to the falls prevention team and different measures had been tried such as removing the door from the person's en-suite as negotiating the door at night was deemed to contribute to the risk of falls. Another person was known to leave their bedroom at night and this posed a risk to their safety and so a motion sensor was placed in the corridor outside their bedroom to alert staff of the person leaving their bedroom. A third person had a moving and handling risk assessment in place instructing staff that two staff and mobilising equipment was needed to support the person to mobilise. We observed staff adhering to this during our visit.

People were living in a safe, well maintained environment and there were systems in place to minimise risks. Risks to the environment were assessed and there were systems in place to minimise the risks, for example in relation to risks from the water system. There was regular testing and monitoring of fire procedures and equipment to reduce the risks of fire and to ensure staff knew how to respond in the event of a fire. External contractors undertook safety checks on equipment and the premises to ensure this was safe. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency.

People could be assured that safe recruitment practices were followed. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider. This meant that the necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

People told us they were happy with the way their medicines were managed. We observed staff administering the medicines and saw they followed safe practice and respected people's wishes. We observed one person receiving their medicine from the nurse and they were given an explanation of what the medicine was and how they should take it. The nurse waited patiently whilst the person took the medicine.

We found the management of medicines, including storage, monitoring, ordering and disposal followed

good practice guidance. We reviewed people's medicines administration records that confirmed people had received their prescribed medicines. Additionally, the way people preferred to take their medicines had been recorded along with any important information the staff required. Detailed information was available to staff with respect to medicines that were prescribed as and when required. This information provided guidance of the administration of this medicine to protect people's safety. Staff had received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines.

Records confirmed that staff had received appropriate training and had received observational competency assessments to ensure they were administering medicines safely. The provider had regular audits and checks in place to assess the on-going safety of medicines practice.

Good

Is the service effective?

Our findings

People were cared for by a staff team who received appropriate training and felt well supported. People we spoke with told us they felt staff were well trained and knew what they were doing. One person told us, "When I've seen them (staff) moving people they know what they are doing and how many people are needed. They do regular checks for sores etc." We observed staff supporting people and saw they were confident in what they were doing, for example using equipment to support people to mobilise.

People were supported by staff who were supported to have the skills and knowledge they needed when they first started working in the service. Staff were given an induction when they first started working in the service. The deputy manager told us that new staff were completing the care certificate and one member of staff we spoke with confirmed this. The care certificate is a set of national standards for staff working in health and social care to follow and equip them with the knowledge and skills to provide safe, compassionate care and support. Staff we spoke with were knowledgeable about their role and the systems and processes in the service.

Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. They told us they felt the training was appropriate in giving them the skills and knowledge they needed to support the people who used the service. We saw records which showed that staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and infection control. Training was also given in relation to the individual needs of people, such as how to support people who lived with dementia.

People were cared for by staff who received supervision and feedback from the management team. This was an opportunity for staff to get feedback on how well they were performing and to discuss any development needs. Staff told us they had regular supervision meetings with the deputy manager or team leaders and were given feedback on their performance and we saw records which confirmed this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported to make decisions on a day to day basis. We observed people decided how and where they spent their time and made decisions about their care and support. We observed staff asked people for consent prior to giving any personal care such as asking if people wanted to wear an apron to protect their clothing at lunchtime and asking if people wanted to eat in the dining room. We observed one person declined to eat in the dining room and this decision was respected by staff.

People were supported by staff who had a good knowledge and understanding of the MCA. The staff we spoke with had a good knowledge of the MCA, how to support people to make decisions and what to do if a

person lacked the capacity to make decisions.

People's support plans contained assessments of people's capacity where there was a doubt they had the capacity to make specific decisions. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed. For example, one person regularly refused their medicines and it had been determined the person did not have the capacity to understand the risks of not taking their medicines. The deputy manager had followed the required process and a multi-disciplinary decision, involving health professionals and the person's relatives, had been made for the person to receive their medicines covertly (hidden in food or drinks). This was clearly documented to show the decision had been made in the person's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was meeting this requirement and the deputy manager had made applications for DoLS where appropriate.

People were supported to eat and drink enough. We spoke with people and relatives about the food and they told us they felt there was enough to eat. One person told us, "Yes, I think it's (the food) excellent." Their visiting relative told us, "Generally the food is good." Another person who used the service said, "There's coffee in a morning with a biscuit and tea in the afternoon with a piece of cake. I don't think you could be hungry." Another visiting relative told us, "The food looks pretty good really."

People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. We saw from the care records of one person that they had been assessed as being at risk nutritionally. There were clear actions for staff to take to monitor this risk and to support the person with their nutrition. Records showed staff were adhering to this, for example monitoring what the person ate. Records showed that people who were deemed at risk of weight loss had been gaining small amounts of weight. We saw that people were being given specialist diets where this had been assessed as a requirement of their care and support.

We saw people were supported to attend regular appointments to get their health checked and if they were unable to attend appointments, arrangements had been made for home visits to be made. People and their relatives told us they felt health care was managed well. One person told us, "I had an issue with my heart some time ago and they dealt with it well. There's always a nurse on and she dialled 999. I can't fault them. They sent [Activity Co-ordinator] to chaperone me when I went for a check-up at hospital." A relative told us about the health conditions their relation had and said, "[Relation] has injections and tablets. They have a nurse here all the time who looks after all that." We saw a relative had also written to the registered manager and complimented the staff in their response to their relations changing health saying, 'I feel the prompt action of nurses and carers prevented [relation] being admitted to hospital.'

We spoke with a health professional who was supporting a person who used the service in relation to their mobility. They told us that staff were following their recommendations and were supporting the person to complete exercises. They told us, "They (staff) take on board what we say." Another health professional commented positively on the health support a person was being given by staff and said, "As [person] is deteriorating, they (staff) are adapting."

Staff sought advice from external professionals when people's health and support needs changed. For

example, records showed that staff had noted one person appeared to be confused, which was not like them and it was documented that a nurse had tested the person's urine and determined the person had a urine infection. The GP had been contacted and they had prescribed antibiotics and the nurse ensured a urine sample was sent off for testing. There were a range of health and social professionals involved in people's care and support such as dementia specialists and physiotherapists.

Requires Improvement

Is the service caring?

Our findings

We were told about and observed mixed examples of people being supported in a caring and dignified way. One relative told us, "You don't tend to see a huge amount of interaction with residents from carers, it's almost like a herding organisation, they seem to be handled as a group. It's almost like they herd them from the lounge to the dining room and then back. They (staff) seem quite caring and understanding of dementia but I don't think they devote enough time to personal interactions." Another relative told us, "There are vulnerable people here and they need carers who genuinely care. Some (carers) are very much nicer than others, some talk to them nicely but a lot of them are just doing a job."

Our observations supported this at times during our visit. We observed lunch in the dining room and saw this was not a positive mealtime experience for everyone. There were very few interactions between staff and people who used the service and the majority of interactions we did hear were about tasks such as the wearing of aprons and giving out drinks and meals. We observed two members of staff did interact with the people they were supporting but other than this there was no chatting or friendly exchanges between staff and people during the meal. The experience was not the social occasion it could and should have been.

One person vomited at the table and staff did not take the person to a private area in a timely manner to protect their dignity and minimise the discomfort of other people eating their meal close by. We observed staff did not work or communicate effectively with each other and did not protect people's dignity, respect and confidentiality when cleaning vomit off the floor. For example, one staff member was heard to loudly say, "I can't touch that I'll be sick" and a second staff member shouted across the room, "Someone's got to clean this up, it stinks." These conversations could be heard across the communal areas of the service and may have caused embarrassment or discomfort to people and their visitors.

We observed that staff placed plastic folders containing people's food and fluid intake on the table next to the person they were intended for and these were left on the tables for the duration of the lunch period. We observed some staff were completing these forms at the table and paying more attention to this than to people who may require support to eat. One member of staff was completing the forms whilst placing spoons of food in a person's mouth. This is a task focused approach and did not promote the person's dignity. We observed a member of staff completing the forms and a person opposite them was not eating any of their meal. Rather than give the person some support and find out if they would like something else to eat the staff member verbally prompted the person without looking at them and whilst completing the records.

There were a few occasions where a member of staff shouted instructions to other staff in a way which was not appropriate in front of people who used the service. On one occasion they shouted across the room to another member of staff who was assisting a person with her meal, asking the staff member to fetch an item. This caused the staff member to stop supporting the person whilst they fetched the item. On another occasion we observed the same staff member shout across the full length of the room to another staff member, who was also assisting a person with their meal, telling the staff member that they had been asked to do something and had not done it.

We observed another member of staff supporting a person to eat their meal. The meal had been in front of the person for over 20 minutes and would undoubtedly be cold. The staff member looked disinterested in supporting the person and we observed they did not interact or make eye contact with the person but simply offered up spoons of food and the staff member sat looking around the dining room in between the person having mouthfuls of food. A further member of staff was assisting a person to eat a dessert. The staff member did this from a standing position with one hand placed on the back of the person's wheelchair and talking across the room to a colleague.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these findings with the registered manager and following our visit the registered manager informed us they had investigated our observations and had taken action to rectify some of the issues and were working towards rectifying the rest.

People's care and support when they reached the end of their life was not always planned for to ensure their needs would be met in the way they would wish. People we spoke with told us that they had been able to discuss and agree end of life plans for their family members with the management team and that this was dealt with in a supportive, sensitive manner. One visiting relative told us, "We have discussed an end of life plan and again [Deputy Manager] was very supportive." However the deputy manager told us two people were currently receiving end of life care and we found that neither person had a designated plan in place which detailed their support needs at this time and so there was a lack of information for staff on how to support both people with care such as mouth care and pain management.

The records of one of these people for mouth care showed considerable gaps in oral hygiene and the other person's fluid intake was very poor due to their condition. A lack of end of life care plans meant there was no instructions for staff on how to ensure these two people received appropriate mouth care. We observed that two people who were in bed did not have their call bells within reach to enable them to summon staff if they needed support. One of these people had a relative visiting and told us, "Very occasionally I come in and the button hasn't been in reach. It isn't now is it?"

In contrast, we received some very positive feedback from some people who used the service and their relatives, who commented positively on staff approach. One person who used the service told us, "The care is excellent, I chose to come here." One relative told us, "I am absolutely thrilled with everything they (staff) do for [relation] here, they are so caring." Another relative told us they felt the service was, "Very good" and added, "It's not just the care they give, it's the manner they give it, there is a great deal of sensitivity and fun." A third said, "I really like it, the staff are superb, a stable staff group, the staff really care." A visiting health professional we spoke with told us, "People (staff) are friendly; the way they talk to residents is lovely."

We saw a relative had written to the registered manager complimenting staff and had written, 'The love and compassion shown to [relation] and also to me was appreciated. Every one of you went over and above to make sure [relation] was cared for.'

We also observed some positive interactions during the day. In the morning we observed a member of staff giving out drinks to people who used the service and to relatives. We saw that one person who had apparently asked for tea then said they wanted coffee. The member of staff said that was "no problem" and we saw they knelt down in front of the person to communicate with them before going to make the coffee.

Relatives told us they felt staff had a good approach to people who lived with a dementia related illness.

One relative told us, "They (staff) try and pacify them, calm them down." Another told us that when their relation was distressed staff calmed and distracted them using family photographs.

People's choices were generally respected. One person told us, "They (staff) are very kind. They do bedtime drinks at 8 o'clock but I said that was too early for me and can I have a drink at 10. They do that." It was recorded in the records of one person that they liked to have a box of tissues with them at lunchtime and we observed the person had their tissues at lunch. We observed catering staff discussing options of meal available to people for lunch and evening meal. We saw in care records that information was recorded to ensure staff knew what choices people were able to make themselves and what they would need support with.

We observed the activities staff were very engaged with people during the day and spent time chatting with individuals and groups. People responded well to this and got engaged in activities. We observed the laundry and housekeeping staff spent time with people who were in their bedrooms. On one occasion, a housekeeper broke off from vacuuming the corridor and went to speak to a person who was in their bedroom. We saw the housekeeper did this in a friendly, gentle manner. One person told us, "It's not only the carers but cleaning staff are lovely, there's one or two who are particularly sensitive." We observed the nurse during the morning and saw they were particularly compassionate and kind when speaking with people who used the service. The nurse ensured they spoke at a level which was appropriate for individuals and took the time to communicate at a pace which suited each person.

People had opportunities to follow their religious beliefs. The service has strong links with a neighbouring church and services were regularly held in the home and people supported to attend the church if they wished. We saw people who required the services of an advocate were able to receive this service. An advocate is an independent trained professional who supports people to speak up for themselves. The deputy manager told us there were three people currently using an advocate and we saw advocacy services were promoted in the reception area at the service.

The deputy manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed relatives visiting during our visit and they were made welcome and had access to a quiet room if they wanted more privacy. One person told us about their visitors being made welcome and said, "They (staff) are very good, they give them tea or coffee." A visiting relative told us, "Staff are very supportive to us as a family." Another relative said that staff, "Care about the family as well as the resident." A third said, "I can come any time I want and they make me welcome".

Good

Is the service responsive?

Our findings

People were supported by staff who were given information about their support needs. We saw people were assessed prior to admission to check that their needs could be met. Care plans were then written to give staff the information they needed to meet the needs of the individual. Where people were able to make their preferred needs known these were recorded in the care plan and if this was not possible then relatives or health and social care professionals who knew the person well had input into the care plan. The relatives we spoke with told us they felt involved in their relation's care and support and that staff kept them updated about any changes. One relative told us, "As soon as I come in they (staff) tell me what is going on with [relation]. I know if there was anything they'd phone me, they have done that in the past."

Staff had a good understanding of people's current needs and there were care plans in place which detailed people's needs and preferences with all aspects of daily living and included tasks people could carry out independently.

The care plans included how people preferred to be cared for and where people needed additional support with a nursing need these were detailed in the care plan with information for staff on how to support the person. For example, we looked at the care records for a person who had a catheter and there was good evidence that an appropriate written plan of care was in place, and that this was followed by staff. The Care Plan stated that the catheter should be changed every three months, in liaison with the continence nurse and that fluid intake and output records should be kept. Records showed that this was being done in practice with clear detailed records of the nursing care given. Fluid intake and output records were being kept with evidence of action taken where issues were identified.

People were supported to follow their interests and take part in social activities. There was a member of staff called the activity co-ordinator who was employed to arrange and implement activities in the service and they were supported on a regular basis by a volunteer. We spoke with the activity co-ordinator and they told us that the programme of activities was driven by what people wanted, saying "I go around on a Monday and ask them what they'd like to do and put the activity chart up."

We saw the activity chart on display was a large, colourful display in the foyer showing the weekly activities in words and images. The Activity Co-ordinator told us, "Not all look at it but some do and it also helps the carers know what's going on." The activity co-ordinator went on to say, "I do group stuff because some like that, bingo etc. but do more individual work. At the moment I'm doing scrap books, memory boxes, they choose what it's based on, the beach, the army; it's all individual to them." They described planning a 60's event and said a recent 50's day event had been a great success. People and their relatives confirmed what the activity co-ordinator had said. One saying, "[Activity co-ordinator] does wonderful things with them. [Activity co-ordinator] sat down and did a lovely memory box with [relation]." Another said, "They have musical motion on Tuesdays and get exercise on Fridays. [Activity Co-ordinator] makes lots of things with them" This relative told us people were supported to get involved in activities and said, "[Activity co-ordinator] does memory boxes with them that reminds them what they used to be like. We went on a boat trip a while back." A visiting health professional told us, "There is always someone doing activities."

The Activity Co-ordinator told us that they ensured they spent time with those people who were confined to their rooms or choose to spend their time there saying "If they are in their rooms I do crafts, read or just sit and talk and perhaps do their nails". People who used the service and their relatives confirmed this. One person told us they chose to spend most of their time in their room and said "[Activity Co-ordinator] comes up, she has a nice friendly manner." One said in regards to their family member, who spent most of their time in their room, "They've done so much for [relation]. [Activity Co-coordinator] comes in and if they are doing something (in lounge) she thinks [relation] will enjoy she'll come and get [relation]."

On the day we visited we observed activities taking place and one activity was throwing bean bags at a target. We saw that the Activity co-ordinator was including everyone in the room though not all wanted to participate. We saw that people were asked if they wanted to play again and some said "yes." The activity co-ordinator had a calm gentle approach and spoke to people in a gentle and kind way and people appeared to be enjoying the experience, smiling and laughing.

People knew what to do if they had any concerns. People who used the service and their relatives we spoke with told us they would speak to the registered or deputy manager or staff if they had a problem or concern. They told us they felt they would be listened to. One relative told us, "If I had any problems then I'd talk to [Deputy Manager] or [Manager]. They are both there if you want them." Another relative told us, "[Deputy Manager] is superb, just knock on her door and she'll talk." One relative told us they had raised some concerns and this had been addressed to their satisfaction.

Complaints were listened to and responded to appropriately. There was a complaints procedure on display and we saw that where relatives had raised concerns these were recorded and included any action taken in relation to the complaint and if the complainant was satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post at the time we inspected. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was registered for another service on the same site and so had a deputy manager, who was a registered nurse, who had day to day responsibility for The Firs Nursing Home. Staff told us the Registered manager often spent time in The Firs and our observations supported this.

The registered provider dedicated one of the volunteers used in the service to carry out a monthly visit to the service to carry out a 'quality monitoring visit'. We looked at the records of these visits and saw that the volunteer spoke with people who used the service, their relatives and staff to gain their views. The audit covered the five key questions of whether the service was safe, effective, caring, responsive and well led and the audits were well detailed with any improvements which the volunteer felt were needed. We saw that the quality audit carried out in August 2017 had a recommendation in relation to staffing levels and the volunteer had noted that the provider may need to provide more money for 'staff on the sharp end' due to 'everyone ringing on the ground whilst trying to get people in for tea.' Despite this, our discussions and observations showed that there continued to be issues with the way staff were deployed in the service.

The deputy manager carried out audits in the service such as infection control audits and we saw these were effective with the service being very clean and hygienic. However there was a lack of audits carried out in relation to care planning and so the issues we found had not been identified prior to our inspection. There was a lack of oversight of wound management , care plan evaluations and records relating to people's on-going health conditions. This placed people at risk of receiving care and support which did not meet their needs.

People who used the service and their relatives commented positively on the deputy manager. One relative told us, "[Deputy Manager] goes above and beyond and has cared for [relation] so well." They went on to describe the help the deputy manager had given and said, "[Deputy Manager] has been so supportive." Staff we spoke with told us they also felt the management team were approachable and supportive. One member of staff described the deputy manager as, "Approachable and listens." They described the deputy manager as 'hands on' and said there was a management presence throughout the day in the service. Staff were also offered the chance to attend meetings in the service to raise any issues or concerns and for the management team to communicate any changes.

The registered manager and deputy manager had a clear understanding of their role and responsibilities. They had processes in place that ensured the CQC and other agencies, such as the local authority safeguarding team were notified of any issues that could affect the running of the service or people who used the service. The registered manager and deputy manager were responsive to input from health and social care professionals who made recommendations for improvement. For example there had been a recent medicines audit carried out by an external health professional and they had made some

recommendations. We looked at the action taken following this audit and saw some of the recommendations had already been addressed and some were in progress.

The registered manager and deputy manager kept a record of compliments received in the service and we saw there had been a recent compliment from a relative who said they wanted to let the staff know, 'how pleased I am with the way [relation] is being looked after' and 'I do feel the way the carers have grasped [relation's] situation and the way they have subsequently kept me informed of how [relation] is doing really is heart-warming and I am glad [relation] is in The Firs. A health professional we spoke with told us, "I would rate them quite highly. I have been very impressed."

Following our previous inspection, we noted the rating for that inspection was on display in the main reception of the home. The provider operated in an open and transparent way ensuring people living at the home, relatives, visitors and healthcare professionals were aware of the home's current CQC rating and where appropriate the areas they needed to improve.

Staff contribution was recognised by the provider with Abbeyfields annual 'Care awards' for staff, who could be nominated by people who used the service, relatives and staff. The deputy manager told us that two staff from the service had been nominated for the last awards, one for their loyalty to a person who used the service who needed additional care and support. The service also valued people who gave up their time to volunteer in the service. There was a designated group of volunteers who carried out roles or be-friended people who used the service.

The management team also ran a scheme for young people to get work experience by working in the service. The deputy manager described the scheme as enabling young adults to learn about communicating with older people and building confidence. The deputy manager told us, "This bridges the gap between older and younger people." This also led to the possibility of future staff recruitment and we were told that one person who did work experience in the service was now a bank worker and also wanted to become a volunteer.

People who used the service, their relations and other visitors were given the opportunity to have a say about the quality of the service. People and their relatives told us that the home issued questionnaires for them to complete regarding the service provided each year. One relative said "I've just done one. I did it with [relation] and they were very positive about things." The deputy manager confirmed this and said that the annual survey questionnaires had recently been sent out to people who used the service and to relatives. We looked at the results of the last survey undertaken in 2016. The survey was based on the five key questions of whether people felt the service was safe, effective, caring, responsive and well led. The results of the survey were mainly positive, although 20% out of 10 of respondents stated they tended to disagree that staff had time to talk to them.

We were told that the home held 'resident and relative' meetings. One visiting relative said, "I have been invited to the meetings and there are notices up in reception but I can't generally get to them." Two relatives told us they were not aware of any recent meetings; however we saw the dates of the meetings were displayed in the reception area of the service. The Activity Co-ordinator told us, "I run Residents' meetings every so often to get a feel about what they want and like." We saw the minutes of the last meeting held in September 2017 and saw people had been given the opportunity to have their say about any concerns they had about the service and any changes they would like to see in the activities. There were no issues raised during the meeting.

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.Regulation 10 (1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems in place to assess risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks were not always robust. Regulation 12(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the services provided were not always robust. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed to ensure service users needs were met in a timely way. Regulation 18 (1)