Firgrove Care Home Limited

Firgrove Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Firgrove Nursing Home is a residential care home providing nursing care to seven people with a range of complex health needs at the time of inspection, including some people living with dementia. The service can support up to 35 people.

People's experience of using this service and what we found
At the time of this focused inspection, due to the risk of COVID-19, people were being supported in their rooms which presented some barriers to being able to talk with people to obtain their views about the home.

Infection prevention and control procedures had been adopted but were not always applied safely. Personal protective equipment was not always used safely and a mobile hoist was moved from one person's room to another without being cleaned in between. The registered nurse on duty failed to wash or sanitise their hands diligently when administering medicines to people. This put people at risk of infection and cross-contamination. Staff wore disposable masks, with disposable aprons and gloves when providing personal care to people.

A system of audits had been established but these were not effective in identifying the issues found at this inspection or in monitoring and measuring the care provided to drive improvement.

New staff were recruited safely and checks were made on their suitability to work in a care setting. Four staff were self-isolating due to the risk of COVID-19, but staffing levels were sufficient to meet people's needs. Agency staff would be engaged to make up any short falls in the number of staff on duty.

A new manager had been recruited and commenced their employment at the home in early July 2020. They were in the process of registering with the Commission.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Inadequate, report published 23 March 2020.
Enforcement action was not taken due to the outbreak of COVID-19 when the decision was taken to postpone or suspend any enforcement proposals.

At this inspection not enough improvement had been made and the provider was still in breach of two regulations.

This service has been in Special Measures since March 2020. During this inspection the provider demonstrated that some improvements have been made. The service is no longer rated as inadequate

overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook this focused inspection to check whether improvements had been made and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Firgrove Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control and in governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Firgrove Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by two inspectors.

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

The service had a manager who was in the process of registering with the Care Quality Commission. When the manager is registered, this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Due to restrictions caused by the coronavirus and visitors going into care services, we gave a short period notice of the inspection. This was to establish the safest and most appropriate way of carrying out our inspection visit during the COVID-19 pandemic. The provider and manager were able to send us documents we requested that related to the key questions we planned to inspect.

What we did before the inspection
We reviewed information we had requested and received about the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one person living at the home about their experience of the care provided. We spoke with the manager, two other members of the management team, a registered nurse, the activities co-ordinator and a member of care staff. We looked at two people's care records in detail, and at two epilepsy care plans, a diabetes care plan and two wound management records. We also reviewed people's risk assessments. We observed how medicines were administered and looked at people's medication administration records. We looked at records of accidents and incidents. We looked at audits and quality assurance records. We looked at three staff files in relation to recruitment and supervision, staff rotas and training records.

After the inspection
Some serious concerns in relation to infection prevention and control were found at inspection. The day after the inspection we asked the manager to prepare a plan to identify the actions they would take to mitigate the risks presented and to address the poor practices by staff which were observed during the inspection.

We also asked the manager to send us feedback from people and their relatives with their views about the home. However, this had not been received at the time this report was drafted.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

At the last inspection, people were not always protected from the risk of abuse and harm. The local authority had a number of safeguarding incidents they were investigating. Since then, all outstanding safeguarding incidents have been looked into by the local authority.

At this inspection, actions had been taken by the previous manager to review and update people's risk assessments, for example, where people had difficulty with swallowing. Concerns about the competency of a registered nurse had resulted in the dismissal of the nurse from their employment at the home. Sufficient improvements had been made. The breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 has been met.

● People were protected from the risk of abuse and harm. One person said, "I feel safe here. I don't feel well today, a bit giddy so I am staying in bed. They took my blood pressure, but it's okay, it's not my diabetes". The person showed us the call bell on their bedside table and told us they were able to call for help if they needed to.
● Staff had completed training in safeguarding vulnerable adults and described the actions they would take if they suspected abuse. A member of the care staff confirmed they had completed their training and that they had read the provider's safeguarding policy. A registered nurse confirmed they had completed their safeguarding training and was able to discuss the different types of abuse.
● Staff followed the appropriate government guidance regarding COVID-19 in relation to self-isolating to mitigate risks.
● Care plans were written in a person-centred way and risks to people had been identified and assessed. However, a Waterlow assessment for one person was only reviewed intermittently. Waterlow is a tool used to estimate people's risks of developing pressure areas. This person lived with diabetes, so their risk of skin breakdown was elevated. The Waterlow chart had been completed and reviewed twice in 2020, in June and July only. This placed the person at risk.
● After the inspection, the provider sent us Waterlow assessments for this person which showed the person's risk of developing pressure areas had been reviewed every month from January until July 2020.
● The person had experienced skin breakdown recently and a pressure wound had developed because of the sling used for moving and handling. A member of the management team explained how this person's pressure area was being controlled, with the use of extra padding in the sling. A registered nurse told us the person's wound had healed and that they had recorded changes to the dressing applied, with a protective

dressing now being used. However, overall the record keeping for wound care was poor and lacked reflection of the cause of the pressure wound. We have written about this further under Well Led.

Staffing and recruitment

At the last inspection, systems were not always robust to ensure all new staff were recruited safely. Checks for two new staff were not sufficient to ensure they were suitable to work in a care setting.

At this inspection, improvements had been made with regard to the recruitment of staff. The breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 has been met. However, other parts of regulation 17 were not met which we have reported on in 'Well Led'.

● Robust systems had now been implemented in the recruitment of staff. Staff files for three staff who had commenced employment since the last inspection showed that all necessary recruitment checks had been undertaken. These included checks with the Disclosure and Barring Service which considered the person's character to provide care. References were obtained and employment histories verified. Nurses had valid PIN numbers. PIN numbers are provided by the Nursing and Midwifery Council to ensure they are legally permitted to carry out clinical procedures.
● The number of people living at the home had reduced from 13 at the last inspection, to seven at this inspection. Staffing levels were adequate and were assessed based on people's needs.
● At the time of the inspection, four care staff were self-isolating and one was due to return to work within a few days. A staff member told us that existing staff could cover the gaps in shifts and that they were also arranging for agency staff to make up any shortfalls.
● A member of care staff said, "We are going to be short of staff, but [named registered nurse] does help out if we need her".

Using medicines safely

At the last inspection medicines were not always managed safely. Medicines were not stored securely. Medicines to be administered 'when required' (PRN) protocols were not person-centred. There was no process for reporting medicines incidents or support learning following any incidents. How people preferred their medicines administered was not always documented.

At this inspection, improvements had been made with regard to the management of medicines. The breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 has been met. However, other parts of regulation 12 were not met which we have reported on in preventing and controlling infection.

● Medicines were managed safely. We observed a registered nurse administering medicines to people at lunchtime; medicines were given to people individually. The nurse collected each medicine from the clinical room, gave them to the relevant person, then returned to the clinical room to sign the medication administration record (MAR). We asked the nurse why they administered medicines in this way and they explained it was because they felt it was safer.
● MARs were completed accurately to confirm each person had received their medicines as prescribed.
● Medicines were ordered, administered, stored and disposed of safely.
● Nurses' competency to administer medicines had been completed.

Preventing and controlling infection

● People were not protected from the risk of infection because of unsafe working practices

● The previous manager and staff had received a high level of support from community nurses after a visit in April when concerns were highlighted in relation to infection prevention and control practice and systems. Community nurses had trained care and housekeeping staff on infection prevention and control and the use of personal protective equipment (PPE).

● We spent time observing staff as they moved round the home and supported people with their personal care.

● We saw a member of the housekeeping staff cleaning one person's room. The staff member wore a face mask, a disposable apron and a pair of yellow 'Marigold' type gloves. They were busy cleaning one person's room and left their cleaning trolley outside the room. The staff member came out of the person's room, cleaned some light switches in the main communal area, then went straight into another person's room. The staff member wore the same pair of gloves as they moved from room to room. The same staff member wore the same disposable apron all morning as they cleaned various areas around the home. This was a cross-contamination and infection risk.

● We observed a mobile hoist being moved from one person's room to another. The hoist was not cleaned between the rooms. The manager later informed us that the hoist was cleaned and sanitised after use in the communal bathroom; this was not what we observed. After the inspection, the provider sent us a copy of a hoist cleaning and sanitising record dated 20 August 2020, but this check was recorded after the inspection on 20 August 2020.

● The nurse on duty who was administering medicines to people did not wash or sanitise their hands in accordance with best practice guidance to prevent the spread of infection. The nurse keyed in the code to the door of the clinical room, entered the room, then handled people's medicines for dispensing. They did not clean their hands after touching the keypad. We asked the nurse why they had not washed or cleaned their hands before dispensing medicines into individual dosset pots; they replied, "I forgot".

● All staff were seen to be wearing personal protective equipment (PPE). There were a number of PPE 'stations' located around the home. However, we saw that disposable gloves were not always available at these PPE stations. For example, a trolley in the atrium communal area contained a roll of disposable aprons for staff to help themselves to, but no gloves, similarly on the PPE station between rooms 11 and 14. The manager explained that staff would go into the kitchen next door to help themselves to gloves if they needed to, but these gloves were solely for light duties, such as taking people their meals or serving drinks.

● We asked the manager and two staff members about the availability of gloves to staff. We were told that they had run out of blue gloves, suitable for delivering personal care. We offered staff the blue gloves that we had brought with us to inspection and these were accepted. One staff member said they had tried to buy some more blue gloves from the local shops, but had not been successful. They assured us that a new supply was to be delivered the next day.

● When we queried the shortage of suitable disposable gloves after the inspection, an email sent in response by a staff member stated that suitable gloves for delivering personal care were freely available for staff to use, just not the blue ones. We were not shown these gloves at inspection. The response also stated gloves were available for staff to use in each person's room by the sink. One person's room we visited did not have any gloves in the room. After the inspection, the provider sent us a copy of a PPE Stock Check which showed there were sufficient stocks of PPE between 24 July 2020 and 13 August 2020. However, supplies of blue disposable gloves could not be located at the time of the inspection.

● Because of the risks at the home presented by COVID-19, people were currently being supported to remain in their bedrooms, behind closed doors. We saw care and nursing staff entering people's rooms, but that they did not don aprons and gloves before entering in accordance with good practice guidance.

● According to a COVID-19 contingency plan that had been drawn up by the provider, staff should don PPE before entering a person's room, but we observed staff did not follow this guidance. Staff did wear masks at

all times, but we observed care staff came into one person's room with the hoist, and they were not wearing disposable aprons or gloves.

Infection prevention and control risks were not managed effectively and put people at risk of unsafe care or treatment. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some aspects of infection prevention and control were managed appropriately. Each person had a COVID-19 contingency care plan which described the actions that would be taken should the virus become active in the home again. These however were not followed.
● When we arrived at the home, the manager took our temperatures and we were shown to a room where we could change.

Learning lessons when things go wrong
● Since the last inspection, action had been taken to address the issues identified in our inspection report published on 23 March 2020. Some improvements had been made.
● For example, medicines were managed safely and the concerns highlighted in the last inspection report had been addressed. Risk assessments had been used to provide advice and guidance for staff on how to support people safely and mitigate risks. Care plans were person-centred. Recruitment systems were effective in ensuring new staff were safe to work in a care setting.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant the service management and leadership was inconsistent. Improvements had been made in some areas, but these needed to be embedded and sustained over time.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

At the last inspection, a robust system of audits to measure and monitor the quality of care and the service overall had not been implemented.

- At this inspection, new auditing systems had been implemented, but further work was needed to ensure audits identified areas for improvement, so that actions could be taken. Audits relating to a number of areas had been completed in the form of check lists and were not effective in highlighting any issues or concerns that needed to be addressed.
- A health and safety audit was completed in July 2020 which documented how the home provided a safe environment for people, but lacked analysis to monitor and improve the quality and safety of the service. Infection prevention and control checks were made and documented, but had failed to identify the issues found at this inspection.
- An accidents and incident audit had been completed on 21 July 2020, and the one before that in March 2020. The previous manager had recorded one incident relating to a member of nursing staff. There was no further information or analysis or guidance for staff on when to report accidents and incidents.
- An audit on the management of medicines was completed in the form of a check list, but was not effective in assessing, monitoring and mitigating risks with regard to medicines.
- An audit completed in February 2020 showed that care plans for 12 residents had been reviewed. However, it was not clear from this audit how changes or improvements should be made to an individual care plan. For example, under 'Nutrition', the audit recorded 'No' against two statements: 'A target amount for fluid intake has been identified …' and how this should be calculated, and 'A choking risk assessment has been completed'. It was not clear which people these statements referred to or any actions that might be needed. The audit had not identified the gaps in one person's Waterlow assessments in relation to maintaining their skin integrity which we found at inspection.
- Two people were assessed as having choking risks. A suction machine was available for staff to use in an emergency, but appeared not to be working. The registered nurse on duty said they did not know the machine was broken, but a new one could be ordered. We raised this issue with the management team. After the inspection, we were told that the suction machine was working, but the cover had not been

replaced correctly. It was evident that the machine had not been used recently and there was no guidance or information available for staff on how or when the machine should be used. People at risk of choking had been assessed, with information about their dysphagia (difficulty with swallowing), which staff followed. People received diets that we modified where required. The provider forwarded us instructions for the suction machine, including operating instructions for staff, after the inspection. However, this was not readily available for staff when we inspected.

Insufficient improvements had been made to monitor and drive up the quality of care provided to people. This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was no registered manager in post. A new manager had commenced employment at the home in early July 2020 and was in the process of registering with the Commission. At the time of the inspection, they were still undergoing their induction and were receiving support from other staff members who had worked at the home for several years.

● One staff member told us they felt confident in their role and another, referring to the impact of COVID-19, said, "It's been a tough time, rotten few months, but I like working here".

● One person told us they were happy living in the home, but would like to go out into the communal areas, as, "I don't like being stuck in my room". We asked why people were confined to their rooms and were told this was in line with the provider's COVID-19 contingency plan. We observed the activities co-ordinator visited people in their rooms to provide them with meaningful pursuits to pass the time.

● After the inspection, the provider sent us a document which showed relatives and residents' meetings took place. For example, a copy of a relatives' meeting which occurred in March 2020 was sent to us and this showed that relatives were informed on issues such as guidance on COVID-19, and relatives visiting the home during the pandemic.

● Restrictions at the home meant that people's relatives could not visit them but social media was used to good effect to ensure people maintained contact with others who mattered to them.

● The manager had been in touch with people's families recently as there were plans to make changes at the home that would affect the care people received. The manager said that relatives had expressed their satisfaction with the care provided to their loved ones.

● After the inspection, the provider sent us copies of questionnaires that had been completed by people and some of the staff at the home. Responses showed that people were generally satisfied with the care they received and staff were positive about working at the home.

● After the inspection, the provider sent us copies of a staff meeting held in June 2020 which informed staff about what was happening at the home and included reminders on working practices. For example, staff were reminded to complete charts for people when any topical creams were used. The provider also sought feedback from others, for example, individuals who came to the home to provide activities or interact with people; comments were generally positive.

● The home worked in partnership with a range of health and social care professionals. For example, on the day of inspection, a speech and language therapist had rung the home to provide advice for one person. GPs maintained contact with the home and consultations were undertaken virtually.