Care Quality Commission

Caring Homes Healthcare Group Limited

Firtree House Nursing Home

Inspection report

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Date of inspection visit: 06 October 2015
Date of publication: 06/11/2015

Ratings

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

Overall summary

The inspection was carried out on 06 October 2015 by three inspectors 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. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people. It was an unannounced inspection. The service provides nursing, personal care and accommodation for a maximum of 50 older people. There were 37 people living at the service at the time of our inspection.

There was a registered manager in post. 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 supported by a deputy manager and a team of nurses and senior carers to ensure the daily management of the service.

Summary of findings

We last inspected the service in July 2014 and found the service was not compliant with the regulations. There were shortfalls in care and welfare, quality monitoring, nutrition, staffing and safeguarding. The provider wrote to us to tell us what action they had taken to improve the service. At this inspection we found that improvements had been made and there were no breaches of regulations.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to report any concerns. People told us that they felt safe using the service.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how risks of recurrence could be reduced.

There were enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were calculated according to people's changing needs. The registered manager had identified shortfalls in the arrival times for some calls and had taken appropriate action to address this. The registered manager followed safe recruitment practices.

People told us that staff communicated effectively with them, responded to their needs promptly and treated them with kindness and respect. People were satisfied with how their care was delivered. The registered manager had clear person centred values that formed the basis of the service and these were followed by staff in practice.

People were supported to manage their medicines in a safe way. Staff responded quickly to changes in people's health and worked with health care professionals to meet their needs.

The registered manager kept up to date with relevant best practice guidance in person centred care and encouraged and enabled staff to improve their knowledge and skills on an ongoing basis. Staff had completed the training they needed to care for people in a safe way. They had the opportunity to receive further training and qualifications specific to the needs of the people they supported. All members of staff received regular one to one supervision sessions and an annual appraisal to ensure they were supporting people based on their needs.

All care staff and management were knowledgeable in the principles of the Mental Capacity Act 2005 (MCA) and the requirements of the legislation. Staff sought and obtained people's consent before they provided support. When people declined, their wishes were respected and staff reported this to the registered manager so that people's refusals were recorded and monitored.

Clear information about the service, the management, the facilities, and how to complain was provided to people. Information was available in a format that met people's needs.

People's privacy was respected and people were supported in a way that respected their dignity and independence. The staff promoted people's independence and encouraged them to do as much as possible for themselves.

Staff knew each person well and understood how to meet their needs. Each person's needs and personal preferences had been assessed before care was provided and were regularly reviewed. This ensured that the staff could provide care in a way that met people's particular needs and wishes.

The registered manager took account of people's comments and suggestions. People's views were sought and acted upon. The registered manager sent questionnaires regularly to people to obtain their feedback on the quality of the service. The results were analysed and action was taken in response to people's views.

Staff told us they felt valued under the registered manager's leadership. The registered manager notified the Care Quality Commission of any significant events that affected people or the service. Quality assurance audits were carried out to identify how the service could improve and the registered manager had an ongoing and effective improvement plan for the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained in the safeguarding of vulnerable adults and were knowledgeable about recognising the signs of abuse.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to safely meet people's needs.

Thorough staff recruitment procedures were followed in practice to ensure people's safety.

People were supported to manage their medicines in a safe way.

The environment was secure, well maintained and cleaned to a good standard.

Good

Is the service effective?
The service was effective.

All staff had completed the training they required to safely and effectively meet people's needs. Staff held a health and social care qualification that enabled them to deliver effective care.

The provider was meeting the requirements of the Mental Capacity Act 2005.

People were referred to healthcare professionals promptly when required and staff worked in partnership with them to meet their health needs.

The premises were suitable for the needs of the people using the service.

Good

Is the service caring?
The service was caring.

Staff knew people well, communicated effectively with them, responded to their needs promptly, and treated them with kindness and respect.

People were involved in the planning of their support. Staff respected people's privacy and promoted people's independence. They encouraged people to do as much for themselves as possible.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed before care was provided. People's care plans were personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when people's needs changed.

People knew how to complain and people's views were listened to and acted upon.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The registered manager and staff held strong person centred values and delivered care that reflected these. There was an open and positive culture which focussed on people.

The registered manager sought people and staff's feedback and welcomed their suggestions for improvement.

Staff had confidence in the registered manager's response when they had any concerns.

There was an effective system of quality assurance in place. The registered manager carried out audits to identify where improvements could be made and took action to improve the service.

Firtree House 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 inspection was carried out by three inspectors and an expert by experience on 06 October 2015 and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people.

Before our inspection we looked at records that were sent to us by the registered manager or social services to inform us of significant changes and events. We reviewed our previous inspection reports. During the inspection we looked at records in the home. They included records relating to people's care, staff management and the quality of the service. We looked at seven people's assessments of needs and care plans and observed to check that their care and treatment was delivered accordingly.

We spoke with ten people who lived in the service and six people's relatives to gather their feedback. We also spoke with the registered manager, the regional manager and eight members of staff in nursing, care, housekeeping and maintenance roles.

Good

Is the service safe?

Our findings

People told us that they felt safe using the service. One person said, “It is safer than being at home, I couldn’t cope on my own.” Another person said, “I trust the nurses and care staff, this is a home you can recommend.” Another person said, “I cannot walk on my own, but they have very good hoists and two staff help you stand up. I feel very safe when they do this.” Relatives we spoke with had no concerns about people’s safety. They told us, “I think the staff treat people well and they are very caring”.

People said there were usually enough staff to meet their needs. One person said, “There is always someone around.” Another person said, “At times they are hard pressed, but most of the time there are enough.” People told us they were reassured by having staff in the service that had worked there for many years. There was a low turnover of staff in the service and some had worked there for twenty or more years. They told us that agency staff were occasionally used and that “Agency staff know their job.”

People told us that they received their prescribed medicines when they needed them. They said that they were offered pain relieving medicines if they needed them.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Staff training records confirmed that their training in the safeguarding of adults was annual and current. The members of staff we spoke with demonstrated their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. One staff member told us, "Nothing like abuse would happen here I’m sure, but if I saw something I would let my manager know straight away.” Another staff member said, “I know that abuse means more than just harming someone. Poor care is abuse too.” Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

There were sufficient staff on duty to meet people’s needs. In addition to care staff the registered manager employed an activities coordinator, a cook, kitchen assistants, two housekeepers and a maintenance worker. The registered provider used a system for assessing the needs of people using the service on a monthly basis to establish the required staffing levels for the service. The rotas showed that the required numbers of staff for each shift had been provided to ensure people’s needs were met. Staff told us they felt there were enough staff on duty to meet people’s needs. The service had two staff vacancies and they had recently recruited new staff to these posts. When staff were on training or holidays the shifts were usually covered by permanent staff who worked additional hours. The service had a contract with an agency. Care staff from the agency only worked in the service once they had completed a full induction. There were enough staff on duty and staff were available to respond to people’s needs and requests within a reasonable time.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. They were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

The environment was safe. The premises had been assessed to identify risks and action taken to minimise these. Risks considered in assessments included any risk to people from equipment, hot radiators or the need for handrails to be fitted. Appropriate windows restrictors were in place to ensure people’s access to windows was safe. Bedrooms were spacious and clutter-free so people could mobilise safely. The bathrooms were equipped with aids to ensure people’s safety. Records in bathrooms showed that staff checked and recorded the temperature of bath and shower water before assisting people with baths and showers. The building had been made accessible for people with mobility difficulties. There was a lift to the upper floors and handrails fitted around the service. People moved around independently or with assistance from staff. The garden was accessible for people to use safely.

Equipment was maintained in good order and had been checked and serviced at appropriate intervals to make sure

Good

Is the service safe?

it was safe to use. Portable electrical appliances were serviced regularly to ensure they were safe to use. A passenger lift that facilitated safe access to the upper floors was serviced yearly. All hoisting equipment was regularly serviced. People's call bells were checked and regularly maintained. Water temperature checks were completed each month to ensure people were not at risk of water that was too hot. There was an effective system in operation for staff to report minor repairs that were required. The maintenance staff undertook repairs within a reasonable timeframe. External contractors were called when needed for larger or specialist repairs. Risks within the premises had been identified and minimised to keep people safe.

The service had an appropriate business contingency plan that addressed possible emergencies and people's temporary relocation to another local residential home. All staff were trained in first aid and fire awareness and fire response strategies were in place. Regular emergency fire evacuation practices took place and the fire alarm system was tested each week. All fire protection equipment was regularly serviced and maintained. There was an emergency box containing the fire book, an up to date register of people living at the service and emergency contact details for people and staff. People had a personal evacuation plan based on their individual needs to tell staff how to evacuate them safely from the building in the event of an emergency. Staff knew what action they needed to take to respond to emergencies and keep people safe.

Staff assessed individual risks to people's safety and the information was recorded and regularly reviewed within their care plan. Individual risk assessments included using the lift, accessing the garden and mobilising independently. The risk of skin breakdown for people with limited mobility had been assessed and staff understood what action they needed to take to help people regularly change their position to avoid developing pressure ulcers. Pressure relieving equipment was sourced and used appropriately. Staff monitored people's fluid intake when they had a change in need or if there was a concern. Some people spent most of their time in their rooms putting them at risk of social isolation. Staff told us that they did their best to spend time with people who preferred to stay in their rooms. We saw that staff spent time in people's rooms other than for giving personal care. One person's care plan identified that they were unable to use their call bell. There was a full risk assessment for this, and the person's care plan reflected that staff should ensure that they checked on the person every two hours. Records showed that showed that staff carried out these two-hourly checks. Accidents and incidents were recorded and monitored by the registered manager to ensure hazards were identified and reduced. They included measures to reduce the risks and appropriate guidance for staff. Action had been taken, such as referring people to the falls clinic, where required to reduce the risk of recurrence. Appropriate action was taken in response to risks to individual's safety and wellbeing.

People's medicines were managed so that they received them safely. The service had a policy for the administration of medicines that was regularly reviewed and current. Staff had received appropriate training and checks of their competence to administer medicines safely. The deputy manager ensured all medicines were correctly ordered and received, stored, administered and recorded. Checks of medicines were carried out to ensure that supplies were sufficient in meeting people's needs. Staff followed the home's medicines policy and administered medicines safely to people, gaining their consent before giving medication and accurately recording the medication given. All medicines were kept securely and at the correct temperature to ensure that they remained fit for use. Where people were prescribed medicines "as and when required" a protocol was in place to ensure that doses were given appropriately. If such medicines were needed for more than three days, the protocol required that the home should refer to the person's GP. People's medicines were managed safely.

People lived in a clean environment. People and their relatives told us that the service was kept clean. One person said, "It is always clean and the cleaners are always happy to do any extra bits we need." Housekeeping staff cleaned surfaces and vacuumed throughout the day. Weekly and monthly cleaning schedules were in place for the communal areas of the service and people's bedrooms. These had been correctly completed and signed by staff. Records showed there had been deep cleaning of bedrooms and carpet shampooing. Staff had a thorough understanding of infection control practice. They described the measures that were taken to ensure that the service was clean and free from the risk of infection. Two members of staff had been nominated as link staff for infection control. There was a file on the nurses' station that contained useful published guidance to staff on reducing the risk of the spread of infection, for example from

Good

Is the service safe?

Clostridium Difficile and MRSA. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. The laundry was clean and well ordered. Staff followed safe procedures to manage soiled laundry to ensure the risks of infection were minimised. Staff washed their hands, used hand sanitizers and encouraged people to wash their hands after using the toilet and before meals. Protective Personal Equipment (PPE) such as gloves and aprons were readily available and staff wore PPE when appropriate. Systems were in place for the safe removal of clinical waste. As the staff took necessary precautions, people's risk of acquiring an infection were reduced.

Good

Is the service effective?

Our findings

People and their relatives told us that they felt the staff were trained to meet their needs. One person said, "They seem skilled and know what they are doing." A person's relative told us "We know the staff receive specialist training with hoists. One day I was watching and a staff had not yet had hoist training so they sent for one who had before proceeding. They are very vigilant."

People said they could see health professionals such as a doctor, chiropodist or optician when they needed to. One person said, "If I am sick they will call the doctor" and another said "I had a fall and the doctor came."

People said they enjoyed the meals provided and had a choice of food and drink.

Staff had appropriate training and experience to support people and meet their individual needs. Staff confirmed they had received a comprehensive induction and had demonstrated their competence before they had been allowed to work on their own. New staff were required to complete the Care Certificate, which is an assessment based learning programme designed for all staff starting to work in care roles. Records showed that all essential training was provided annually, was current and that staff had the opportunity to receive further training specific to the needs of the people they supported. Staff had completed in depth training courses in dementia and person centred care. Staff told us that they were provided with sufficient training to carry out their roles. One staff said "The training is very good here, there is something every month." Most staff had completed a relevant health and social care qualification and newer staff were registering to do so after they had completed their induction. Staff were able to show that they applied the skills and knowledge obtained in training to their everyday practice, for example by following safe moving and handling procedures. This ensured that staff were skilled and competent to provide care to people.

Staff had a supervision meeting with their manager every eight weeks. Staff said this was an opportunity to discuss their work and to identify any further training or support they needed. All staff had an annual appraisal of their performance. These had been completed in June 2015. There was a programme of development in place to help nurses retain and renew their professional registration. Regular team meetings were held and staff told us that they were able to contribute ideas for improvement of the service. Staff felt supported in their roles.

Staff understood how to support people who could not consent to their care or make their own decisions about their care and daily routines. Staff had completed training on the Mental Capacity Act (MCA) (2005), including Deprivation of Liberty Safeguards. The service had a dementia champion, whose role included supporting staff in the practical application of the Act. The staff we spoke with had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. One staff member told us, "I think the most important thing is that people can make decisions for themselves unless it's proven otherwise." Another staff member told us, "I know about best interests meetings. We can't just make decisions about people without making sure it's right for them." People's care plans contained up to date mental capacity assessments. 'Best interests' meetings had been held when a person who lacked mental capacity was not able to consent to treatment that may be beneficial. The best interests meeting was attended by staff, family members an Independent Mental Capacity Advocate (IMCA) and a Consultant Surgeon. The conclusions reached were consistent both the provider's policy and current legislation.

Written consent had been sought and obtained in a variety of areas. These included photography for identification purposes and consent for outside agencies, such as the Care Quality Commission, to examine care plans. A person's relative told us, "I'm really particular about consent. My relative has difficulty with communication, but I've noticed the staff always ask them before doing anything. They take the time to ask and if they don't want to do something, they respect that." People were asked for their consent and supported to make decisions.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The purpose of DoLS is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. We discussed the requirements of the DoLS with the registered manager and they demonstrated a good understanding of the process to follow when restrictions needed to be used for people's

Good

Is the service effective?

safety. They had made applications to the appropriate authority as needed and followed the conditions set in any DoLS authorisations. Staff were confident in describing the implications of DoLS for the people they were supporting.

People were provided with sufficient food and drink to meet their needs. They were provided with a choice of meals. This included vegetarian options and meals suitable for people with a range of specific health conditions, such as diabetes. There was a 24 hour snack menu and food fingers were provided if people found these easier to manage. One staff member told us, "We have good communication with kitchen staff. If there's any change in people's diets we will let them know." Another staff member said, "We have training on this as it's so important. Some people have special diets so we need to know what we're doing." People at risk of poor nutrition were regularly assessed and monitored using the Malnutrition Universal Screening Tool (MUST). 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. We also noted that people with special dietary needs were regularly assessed by external professionals such as dieticians. People's care plans showed that advice and guidance given by professionals was followed by staff.

Staff asked people what they wanted for their meals. Staff knew people well and knew what their likes and dislikes were. People were asked what portion size they preferred when the meals were served and were offered second portions. Staff provided people with hot drinks when they requested them and offered tea and coffee at various points of the day. Jugs of cold drinks were available in the lounges for people to help themselves. A person's relative told us they were happy with the quality of food and drinks on offer. They told us, "My mum had lost quite a lot of weight before coming here, but she's put it all back on now. I think the food is excellent". People were supported to have sufficient to eat and drink.

People's wellbeing was promoted by regular visits from healthcare professionals. Staff enabled people to see their GPs regularly as needed to promote good health. One person had not needed to see their GP for a year and staff had supported the person to see their GP for a review to ensure their continued wellness. An optician visited people annually and a chiropodist visited every six weeks to provide treatment. People were supported to see a dentist when necessary. Where people required input from a healthcare specialist this had been arranged. Staff ensured that people's health appointments were made when they needed them and that they were supported to attend these. The outcome of health appointments was recorded within people plans so that staff knew what action to take. We reviewed the care plans of two people who had diabetes. We saw that their blood sugar levels were monitored and recorded and that medication was given in line with their care plans. We also saw that staff ensured that these people regularly saw an optician and a chiropodist in the home because people with diabetes are at increased risk of developing certain eye and foot conditions. People had their health needs planned for and met.

The premises met the needs of the people that lived there. Accommodation was designed to allow people to move safely around the premises. Handrails were fitted to allow people to stabilise when moving around. There was a shaft lift to enable people to move between floors. There were sufficient toilets and bathrooms across the service for people to use. Bedrooms were personalised and people had been able to bring items of furniture and personal belongings from home if they wished to. The registered manager had taken into account people's needs when providing accommodation, for example staff told us that people with the highest needs were located nearer to the nurse's station. There were a number of areas around the service that people could use including two lounges, a conservatory and a dining room. The garden was provided a safe and well maintained area for people to use. People had accommodation and facilities that met their needs and promoted their independence.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and compassionate and they said they felt well cared for. One person said, "They are very kind and you cannot fault them." Another person said, "I have fun with the staff. My favourite is X, he makes me laugh." Another person said "They will stay for a chat." One person said their relative was receiving end of life care. They told us, "They let me stay with him every day. They even give me lunch. They support me very well and they are very caring. They treat us both with dignity and respect." Another person's relative told us, "I can't fault the staff here. They really do care and they seem to have the time to get to know people. I think a lot of the staff have been here a long time and that speaks volumes."

People told us they were able to make decisions about their care and how they spent their time. One person said, "I make my own decisions." People told us that staff respected their decisions. One person said, "I don't mind if I have a male or female carer, they are all kind and do their best to help you, but they would respect my decision is I had a preference." Another person told us "I like to stay in my room and watch TV, they know and respect that."

People told us their friends and relatives could visit at any time and were made to feel welcome.

Staff were caring and kind in their approach towards people and they were sensitive to each individual's needs, giving reassurance where needed and encouraging people. One staff member told us, "We're encouraged to spend time with the residents and to get to know them. The manager is very keen that we do." Another staff member said, "The jobs we have to do can wait most of the time. The manager says it's more important that we put the residents first." Staff understood how to provide compassionate care that met the specific needs of people living with dementia. When people became confused they took time to find out what the person needed and provided comfort and support.

Staff had positive relationships with people that respected their individuality. Staff took time to chat with people during the day. They were polite when talking with people, but also engaged in appropriate light-hearted conversations with people that created a relaxed and pleasant atmosphere. Staff involved everyone in conservations. Staff responded positively and warmly to people. Staff took care to provide care and support at an appropriate pace to meet people's needs.

Staff knew people well. People's care plans contained both life histories and social assessments. They had been compiled in conjunction with people and their families where possible and contained information staff could use to help build relationships. For example, we noted activities care plans had been drawn up for each person with a plan to match the provision of social, educational or occupational activities with a person's interests before coming to the home.

People were involved in decisions about their day to day lives and their care. People and their representatives had regular and formal involvement in care planning and risk assessment if they wished. This was established on admission to the home when an 'Individual Preferences' form was completed. People's views were sought on care plans and risk assessments; consequently, there were opportunities to alter the care plans if the person did not feel they reflected their care needs accurately. No one in the home was receiving advocacy services at the time of our inspection. Staff we spoke to understood the need for advocacy and could describe the process for applying for an advocate for people if they required one. Staff promoted people's independence and encouraged people to do as much as possible for themselves. A person's relative said, "It's plain to me that my mum can do a lot more for herself than when she first came in. I've watched them (staff) and they're very patient. They don't just do things to people. They try to get people to try for themselves even though it takes longer."

People's right to privacy was respected. Staff knocked on people's bedroom doors, announced themselves and waited before entering. Staff addressed people by their preferred names and displayed a polite attitude. A person's relative told us that staff maintained people's dignity and privacy. They said, "There's no problem there. I've never felt that my relative wasn't treated with the utmost respect, like I would want to be treated." People's records showed that they had been asked about their preference for a male or female member of staff for their personal care and staff knew who had particular preferences. Staff respected people's privacy and confidentiality.

Good

Is the service caring?

People were assisted with their personal care needs in a way that respected their dignity. People were able to access a hairdresser in the service each week. We spoke with the home's dignity champion about their role. They told us, "It's partly a training role and partly monitoring. If I see something that perhaps could be improved I'll point it out to staff, but not in a severe way, and maybe include it in training. For example I came across a couple of staff who were speaking to each other in their own language in a communal area. I asked them to speak English as it might confuse or upset the residents. The staff were okay with it, but it's that awareness I'm trying to promote." We noted the dignity champion's job description contained key aims, the purpose of the role, personal qualities required and tasks and duties. These were in line with current Department of Health guidelines.

Good

Is the service responsive?

Our findings

People told us that the service was flexible and provided care that met their needs. One person's relative said the nursing staff had made adjustments to their relative's diet as they had lost weight. They told us, "They give her milk instead of tea sometimes, especially at night when she has hot milk to try and help her increase her weight." People told us that their care was delivered in the way they preferred. One person said, "They take notice of how I like things done." Another person said, "They do some lovely activities here, we had a lovely barbecue a few weeks ago." A person's relative told us that they were involved in reviewing their relatives care. They said, "I can talk to the Nurses and the manager at any time to discuss changes to her care."

People knew how to make a complaint. One person said, "I can discuss anything with the Nurses or Manager at any time." Another person said' "I have no hesitation in approaching the Manager" and another person said, "She often drops in for a chat, she is around all the time." People's relatives knew how to make a complaint if they needed to and said they would be confident to do so.

Each person's needs had been assessed before they moved into the service. This ensured that the staff were knowledgeable about their particular needs and wishes. People's care plans contained detailed information about their care needs, for example, the management of the risks associated with people's dietary needs and the risk of falling. The care plans also contained detailed information about personal histories and likes and dislikes. People's choices and preferences were also documented. The daily records showed that these were taken into account when people received care, for example, in their choices of food and drink. A person's relative told us, "It's obvious they take the time to get to know people and find out what best suits them." Staff understood by the term 'person centred care'. One staff member told us, "It's putting the resident at the centre of what we do." Another staff member said, "It's good care isn't it? It means we're doing things with residents and not at them."

Care planning and individual risk assessments were reviewed monthly or more frequently if required so they were up to date. There was good communication in the management of people's care between the provider and external professionals such as GPs and community nurses.

The risk assessments were focused on the individual and were relevant to the care needs of people. For example, we noted that one person occasionally presented with challenging behaviour and was verbally aggressive to staff from time to time. This person's care plan contained a behaviour risk assessment. It described potential triggers for aggression and the de-escalation techniques to be used in order to support the person and keep other people safe.

The service provided a wide variety of social and educational opportunities for people, mainly within the home. There was a weekly and quarterly activities rota, which was distributed throughout the service. The social activities programme had been designed to incorporate the five areas of physical, emotional, sensory, social and cognitive activities. There was a monthly newsletter specific to the service and one from the Caring Homes Group. There was provision made to interact with people on a one-to-one basis if they desired on a daily basis. Staff discussed activities with people at residents' meetings to decide what should be included in the schedule and people could approach the activities co-ordinator with suggestions or ideas at any time. Similarly, if someone did not want to participate in group activities, their wishes were respected. For example, one person did not wish to take part in the recent VE Day celebrations as it brought back painful memories for them. We noted separate arrangements were made for that person to respect their feelings and experiences. During the inspection one person being supported to bake some cakes. Staff ensured that people in the lounge were watching a TV programme that was of interest to them, and involved people in choosing an alternative programme to watch. People were asked how they wanted to spend their time and their wishes respected.

People's views were sought and listened to. The provider held monthly residents' meetings and three monthly relatives' meetings where people and their families were able to discuss matters of importance to them with staff. There was also a residents' committee, facilitated by the provider, but run and managed by people living at the home. Staff described how this was organised. One staff member said, "We provide the room and we can make suggestions for topics for discussion, but we don't attend unless they want us to. For example, we are looking at refurbishing part of the home so we suggested that might be worth discussing so people can come up with ideas. That could then go to the residents' and relatives' meetings

Good

Is the service responsive?

for people to look at." The service sent a series of annual questionnaires to people's relatives or representatives to gather their views on the care and support provided, activities, the food, the environment and management.

People were aware of the complaints procedure. They told us they felt confident to raise any concerns and felt the registered manager would take them seriously. People told us they did not have cause to complain. Complaints had been handled appropriately and responded to quickly.

Good

Is the service well-led?

Our findings

People told us they were satisfied with the service they received. One person said, "It is all very good, I have no complaints." People said they felt the home was well managed and they found the registered manager friendly, approachable and open to suggestions.

The service had a clear vision and set of values that were person centred. The care that people received was person centred and appropriate to their needs. All of the care staff members we spoke with were aware of the 'Duty of Candour' and were able to describe its relevance and application. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The registered provider had ensured that all staff understood the principles as part of promoting and open and honest culture in the service.

Staff told us they felt supported in their roles and that their views were sought and listened to. An annual survey of staff views was carried out and there was an action plan in response to the results. One staff said, "I really enjoy working at Firtrees." Another said "It starts at the top. If you have good leadership you have good team work and a good care home." Staff told us that they could raise suggestions for improvement with the manager and that their ideas would be listened to. A staff member told us, "I would have no hesitation in reporting any concerns I might have to the manager." Staff were clear about their roles and responsibilities. There was a set of policies and procedures that were appropriate for the type of service, reviewed annually, up to date with legislation and fully accessible to staff. Staff had signed to confirm they had understood the policies relevant to their role. Staff were confident in their roles and knew what support people needed.

The registered manager participated in meetings with other managers of similar services to exchange views and information that may benefit the service. The registered manager told us they used relevant social care and nursing practice websites such as Skills for Care and the Social Care Institute for Excellence to stay up to date with changes in legislation and good practice guidance. Staff told us that the registered manager shared new and interesting practice information with them. Records indicated the manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept them involved in decisions concerning their safety and welfare. The registered manager understood their legal responsibilities and consistently notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with stakeholders.

People's records were kept securely. All computerised data was password protected to ensure only authorised staff could access these records. People's care records were detailed and provided staff with clear information about how to meet their needs. Daily records of the care provided to people reflected the care required by their individual plan. The records were sufficiently detailed to allow the registered manager to monitor that people received the care they needed.

A wide range of audits were carried out to monitor the quality of the service. Monthly checks were made of areas of the service, such as infection control and the safety of the premises to ensure that people were safe and the service met their needs. Where shortfalls had been identified action had been taken quickly to fix this. There was a plan in place for renewing lighting in some areas of the service to improve visibility for people moving around. The registered manager carried out regular spot checks of the response time to call bells and had researched and ordered an electronic system for monitoring this in more detail. Systems for reviewing and improving the quality of the service were effective.