Georgia Rose Residential Care Limited

Firbank Residential Care Home

Inspection report

8 Crescent Road
Shanklin
Isle of Wight
PO37 6DH

Tel: 01983862522

Date of inspection visit:
18 August 2016
22 August 2016

Date of publication:
25 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on the 18 and 22 August 2016 and was unannounced. The home provides accommodation with personal care, including people living with dementia for up to 22 people. At the time of the inspection there were 21people living at the home, all of whom were older people with physical frailties and some with dementia.

The home was based on three floors, connected by a passenger lift and stairwells. Not all bedrooms had en-suite facilities but there were toilets and bathrooms available on each floor. People had level access to the front garden, but did not have full access to the rear garden due to uneven ground. There was a choice of communal spaces comprising of two communal lounges and one dining room where people were able to socialise.

There was a registered manager at the home. A registered manager is a person who had 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.

Some of the environmental risks had not been assessed by the provider, including visitor access and internal stairs placing the people at risk. Other environmental risks had been identified in an audit completed by the home, however not all risks highlighted had been addressed or rectified.
This included floor covering in bathrooms and toilets and some beds and furniture being in a poor state of repair, resulting in them being difficult to clean effectively and therefore an infection control risk. Individual risks to people, such as the risk of falling or developing pressure sores were not always managed effectively and care plans in place to support staff to manage risks were not always followed. Environmental risks and risks to people were raised with the registered manager at the time of the inspection who agreed that appropriate action would be taken to reduce these risks.

People's privacy was not always repected by all the staff. Staff were seen entering people's rooms without knocking or requesting admission and staff were heard talking about the people where they could be over heard.

Staff sought verbal consent before providing care and treatment, however the service did not always follow the principles of the Mental Capacity Act, 2005 (MCA). Where people lacked the capacity to make specific decisions, staff had made decisions on their behalf. Assessments of people's capacity to make these decisions did not follow the standard two-stage test and family members had not always been consulted. Therefore, the provider was unable to confirm that the decisions had been made in the best interests of people. We have recommended that the provider seek advice and guidance on adopting the latest best practice in respect of recording assessments and decisions under the Mental Capacity Act.

People were having their liberty restricted without appropriate authorisation and applications to restrict

people's movements, where appropriate had not been made. Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The service had not gained legal authorisation to deprive people of their liberty, yet the service was restricting people's movements.

Meaningful activities were not organised to promote people's welfare. A staff member had been assigned to arrange activities, but the registered manager acknowledged they had not been given sufficient time to do this. They had managed to speak with people about activities they would wish to take part in and these were recorded, but no action had been taken to arrange them. We have recommended that the provider seek advice and guidance on adopting the latest best practice in respect of providing meaningful activities for older people and those living with a cognitive impairment.

People's needs were met by staff who were suitably trained. The registered manager had a system to record the training that staff had completed and to identify when training needed to be repeated. People were happy with the personal and health care provided and confident in the staff's abilities.

People and their relatives were complimentary about the quality of the food and the people received a choice of suitably nutritious meals.

Staff demonstrated a good awareness of the individual support needs of people living at the home. They knew how each person preferred to receive care and support. Care plans provided comprehensive information about the people to support staff to provide personalised care in a consistent way.

People were treated with kindness and compassion in their day-to-day care and all of the people we spoke to were very positive in their comments about the caring attitude of the staff. Staff recognised when people became confused or anxious and responded to this with support and reassurance.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident that these would be resolved. Visitors were welcomed and there were good working relationships with external professionals. People were supported to access health care services when needed. Records showed people were seen regularly by doctors, specialist nurses, community nurses and chiropodists. Healthcare support and advise was requested in a timely manner and when appropriate.

There was a clear management structure in place and the people we spoke with enjoyed living at Firbank and told us it was well-led. The staff described the management as 'supportive' and 'approachable'. There was an open and transparent culture at the home.

The registered manager was responsive to concerns we identified during the inspection and made arrangements for these issues to be addressed promptly.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we have taken at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's and risks posed by the environmentment were not always identified or addressed.

Infection control risks were not managed effectively.

People were protected from the risk of abuse; staff knew how to identify, prevent and report abuse.

Appropriate recruitment practices were in place and arrangements. Staff understood how to keep people safe in an emergency.

People received their medicines safety, at the right time and in the right way to meet their needs. Medicines were administered by staff who had been suitably trained and assessed as competent to administer them.

Is the service effective?

Requires Improvement

The service is not always effective.

The service did not always follow legislation designed to protect people's rights.

Staff were suitably trained and supported in their roles. Staff was able to demonstrate an understanding of the training they had received and how to apply it.

People praised the quality and variety of the food and people's nutritional and hydration needs were met. Staff took appropriate action when required to protect people from the risk of malnutrition or dehydration.

People were supported to access healthcare services when needed. Records showed people were regularly seen by healthcare professional. There was evidence that healthcare support and advice was requested in a timely manner, when appropriate.

Is the service caring?

Requires Improvement

The service was not always caring.

The privacy of the people was not always respect.

Staff did not always respond to people's communication needs. Staff attempted to supported people to express their wishes and make informed choices verbally but did not always use visual aids to assist the people who found it difficult to understand the choices offered.

People were treated with kindness and compassion in their day-to-day care.

Staff recognised when people became confused or anxious and provided support and reassurance and positive interactions between people and staff were observed.

Staff supported the people in a patient, caring way, giving clear instructions and encouragement to the person throughout.

Is the service responsive?

Requires Improvement

The service is not always responsive.

Meaningful activities were not organised to promote people's welfare.

The registered manager sought feedback from people, their families and the staff through quality assurance questionnaires, however some of the issues raised were not followed up or acted upon.

Staff demonstrated a good awareness of the individual support needs of people living at the home. They knew how each person preferred to receive care and support.

Care plans provided comprehensive information about the people to support staff to provide personalised care in a consistent way.

People were encouraged to remain independent. Information in care plans explained people's abilities and what tasks they needed support with.

Is the service well-led?

Requires Improvement

The service is not always well-led

There is limited and infrequent opportunities for people to engage with the local community.

Quality assurance systems and processes were not always effective and did not always ensure that action was taken to maintain standards.

There was an open and transparent culture at the home.

Most people enjoyed living at Firbank and felt that it was well organised.

Staff described the registered manager as "amazing", "supportive" and "approachable" and felt that the home was well run and organised. There's a low turnover of staff and we all work well as a team."

The registered manager was responsive to concerns we identified during the inspection and made arrangements for safety issues to be addressed promptly

Firbank Residential Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 22 August 2016 and was unannounced. The inspection team consisted of two inspectors and one 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 we reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people living at the home and six visitors. We also spoke with the registered manager, the deputy manager, two senior care staff, three care staff and one member of the domestic support team. Following the inspection we spoke with a health professional who often visited the home.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas. 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.

The home was last inspected on 20 January 2014 when no issues were identified.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm as not all risks posed by the environment had been assessed by the provider. For example, the front door of the home was kept wide open, so people could come and go as they pleased. Visitors were required to sign in and inform a member of staff of their presence. However, we observed that staff were often not present in the reception area to check visitors and no equipment was in place to alert staff to people entering and leaving the home. Therefore, visitors were able to access most areas of the home without challenge, placing people at risk of harm. The stairs between the ground floor and lower ground floor was long and steep. Although there was a door at the top of the stairs, it was not locked, so the stairs could be accessed by people. This posed a significant risk, particularly to people living with dementia or with poor eye sight who may not appreciate the danger. We raised these issues with the registered manager, who told us they had not considered the risks before, but would now review them.

The carpets in two people's rooms were torn near the doorways which posed a trip hazard. The risks had been identified in an audit conducted a number of months before the inspection, by the registered manager, but had not been addressed. A further trip hazard was identified at the entrance to the ground floor lounge where the threshold strip between two carpets was not properly secured. A person told us they had mentioned this to staff a few days previously. We brought this to the attention of the registered manager, who covered the strip with protective tape to reduce the risk. We also found that a lobby area on the lower ground floor, which was a fire evacuation route, was obstructed with laundry bins and a clothes airer. These would delay the evacuation of people with limited mobility in the event of a fire.

The risks of people falling were not always managed effectively. For example, one person had a history of falling, but guidance in their care plan stating they needed to be supported to moblise to reduce the risks was not always followed. The use of equipment not been considered to alert staff to the person attempting to mobilise independently. Action had been taken to protect another person, by using bed rails to prevent them from falling out of bed. An assessment of the risk of the person becoming entrapped in the bed rails had been completed. However, the risk assessment had not assessed the possibility of the person climbing over the bed rails and suffering greater injury.

There was no process in place to analyse falls across the home, in order to identify patterns, such as common times or places where people fell, so that measures could be put in place to reduce the frequency of people falling. We discussed this with the registered manager and by the end of the inspection they had implemented an updated form which would allow them to analyse incidents more thoroughly.

The provider required staff to complete accident forms when people were injured, so that the registered manager could investigate the cause and take action to prevent a recurrence. One person showed us an injury to their leg, which they said was caused by a wheelchair. An accident form had not been completed. The registered manager told us they were not aware of the incident, so had not completed an investigation to establish how it had been caused or how future injuries could be prevented.

People were not always protected appropriately from the risk of pressure injuries. Staff knew how to care for people's skin and to reduce the risk of skin breakdown. However, special mattresses used to reduce the risk of pressure damage were not set correctly, according to the person's weight, so may not have been effective. Also, there was no system in place to help staff ensure mattresses remained at the correct settings. We discussed this with the registered manager, who took action to adjust the mattress settings and introduce a procedure for checking the settings on a regular basis.

The failure to assess and mitigate the risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of infection as the home was not a clean and hygienic environment. For example, floor coverings in the toilets were not in a good state of repair. They were stained and curling up at the edges, which created bacteria traps. The bedding on one person's bed was stained, as was the base of another person's bed. The arms of an armchair in the lower lounge were heavily soiled and worn, so could not be cleaned properly.

Care staff used soluble red bags for linen that was heavily soiled or potentially infectious and these were placed directly into washing machines. Although staff had received training in infection control, three staff members who operated the laundry were not clear about the appropriate temperature setting to use for such linen and two specified temperatures that were not appropriate.

Best practice guidance, issued by the Department of Health, recommends the use of pedal operated waste bins for waste such as used gloves, aprons and continence pads. Not all bins in the home were of this type. Some posed a risk of cross infection as their lids had to be touched to open them. Large clinical waste bins were stored in the front garden of the home, which were accessible to people. The bins were not locked and would pose an infection risk if opened by people, for example those living with dementia who may not recognise the danger.

The failure to maintain a hygienic environment and follow safe procedures to prevent and control the risk and spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were sufficient staff to meet their needs. One person said, "If you ring your bell someone will come and help you, it makes you feel secure." A relative told us, "I don't worry. The staff are very attentive and they are so quick to answer the bell."

Although call bells were responded to promptly during the inspection, we found people were left alone in communal areas for up to 25 minutes. During one of these periods a person at high risk of falling attempted to self-mobilise. We, together with a visitor, had to intervene to prevent the person from falling. The person told us, "There's no staff about."

Staff had mixed views about the staffing arrangements. They told us that when the home was fully staffed, they were usually able to meet people's needs. However, when staff reported sick, they found it difficult to provide the necessary level of support, especially at weekends when managers were not available to provide support.

The registered manager told us they based staffing levels on people's needs. They said they were in the process of recruiting an additional staff member between the hours of 15:00 and 18:00 as some people were unsettled at these times, but would also be used flexibly at other times of need.

Staff recruitment procedures were robust. Pre-employment recruitment checks were completed, including with the Disclosure and Barring Service (DBS). These checks are made to see whether the applicants are on a list of people barred from working with vulnerable adults. Staff confirmed that all checks were completed before they started working at the home.

People received their medicines safety. Medicines were administered by staff who had been suitably trained and assessed as competent to administer them. Suitable arrangements were in place for the ordering, storing, administering and disposing of medicines. Medicine Administration Records (MAR) were used to record the administration of all medicines and were signed by staff to confirm the medicines had been given as prescribed. However, there was no process in place to account for the quantity of medicines in stock. We discussed this with the deputy manager, who agreed to implement a process for this.

People were protected from the risk of abuse and staff were clear about their safeguarding responsibilities. They knew how to identify, prevent and report abuse. One staff member said, "I'd have no hesitation in reporting any concern to [the registered manager]." They also knew how to report concerns to external bodies, such as CQC or the local safeguarding authority.

There were arrangements in place to keep people safe in an emergency; staff understood these and knew where to access the information. Staff knew what action to take if the fire alarm sounded; they completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Personal emergency evacuation plans were available for people and included details of the support each person would need if they had to be evacuated.

Requires Improvement

Is the service effective?

Our findings

People told us that staff always sought verbal consent before providing care. One person said, "They [staff] would never do anything I didn't want them to." We heard staff gaining verbal consent from the people before providing them with care and treatment, such as offering to help them mobilise or to have an assisted wash. A staff member told us, "I will always ask first'.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. 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. No DoLS applications had been made or authorised, yet staff told us they would prevent some people from leaving the home unsupervised as they would be at risk. A staff member told us, "If [a person] tried to leave [without staff support], I would invite them back through talking and distraction; or would maybe take them for a walk around the garden. I wouldn't let them go". Another staff member said "I would stop [the person] from leaving". Not all staff had received trained in MCA and DoLS and did not recognise that they were depriving people of their liberty unlawfully.

The failure to protect people from being deprived of their liberty without lawful authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff did not always follow the principles of the Mental Capacity Act, 2005 (MCA) and its code of practice when planning people's care. The 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 make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the capacity to make specific decisions, staff had made decisions on their behalf, but had not recorded them. These included decisions relating to the care and support people received, the administration of their medicines and the use of bed rails. Prior to making decisions on behalf of people, staff had not completed the required two-stage test to assess the person's capacity to make the decision or consulted with family members. Therefore, staff were unable to confirm that the decisions were necessary or had been made in the best interests of people. We discussed this with the registered manager who took action to review the way people's capacity was assessed and recorded during the care planning process.

We recommend that the provider seek advice and guidance on adopting the latest best practice in respect of recording assessments and decisions under the Mental Capacity Act.

People were satisfied with the personal care provided and relatives were confident in the staff's abilities. One relative told us, "I'm really happy with the care that [my relative] gets, I don't have to worry." With the

exception of MCA and DoLS, staff had received suitable training to meet people's needs. Ancillary staff, such as housekeepers, completed the same training as care staff to help them understand people's needs. An ancillary staff member told us, "We do all the training. It's given me a real insight into [people living with dementia] I now make time to speak with them in a kind, caring and patient way."

New staff completed an induction programme and worked alongside experienced staff for a period of time before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, most staff had obtained, or were working towards, vocational qualifications in health and social care.

Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques. They explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance and we saw them putting this into practice.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal, with the registered manager, to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from management on a day to day basis. One staff member said, "Supervisions are good. We talk about training, any changes we want and any improvements we can think of." Another staff member told us, "In my last supervision, I asked if I could do my NVQ 2 [a vocational qualification], which I've now started."

Supervisions included observations of staff practice to check they were working to appropriate standards. The registered manager told us these were based on themes. For example, during recent supervisions, they had observed staff hand washing techniques. Previous themes had included medicine management and the use of equipment to support people to reposition.

People and their relatives were complimentary about the quality of the food. One person told us "The food is out of this world." Another said, "The food is really good." Drinks were available to people and within reach, together with a variety of cups and beakers to suit people's needs. Snacks were available throughout the day and night if requested; for example, one person had asked for, and been given, sandwiches during the night when they were unable to sleep.

There was a choice of two main courses and two desserts daily with a cooked snack at teatime. Cooked breakfasts were also offered to people. They were encouraged to eat well and staff provided one to one support where needed. Staff were aware of people's dietary needs and people who needed their meals prepared in a special way. One person who needed full support to eat received this effectively, in a quiet area where staff could engage with them individually. Another person's choice to have pureed meals was respected and the meal provided was attractively presented.

Staff closely monitored how much people ate and drank, through the use of food and fluid charts, weight monitoring and nutritional assessments which were kept up to date. They took appropriate action when required to protect people from the risk of malnutrition or dehydration, for example by referring them to doctors or specialists.

People were supported to access healthcare services when needed. One person told us, "A Doctor visits us every week, but if I need one quicker I usually see one the same day." Records showed people were seen regularly by doctors, specialist nurses, community nurses and chiropodists. They also had access to dental care and eyesight tests when needed. Healthcare support and advice was requested in a timely manner, when appropriate. Staff demonstrated an awareness of people's physical health needs and were able to tell us what they would do if a person was unwell and the signs and symptoms they would look for. For example one person had a change in behaviour and mood and staff suspected a possible urine infection. They sought involvement from healthcare professionals and provided effective and appropriate care as needed. A health professional told us, "Firbank is forward thinking. They bring any concerns to our attention as needed and follow our advice. They're on top of everything."

Requires Improvement

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives were positive about the caring attitude of the staff, who they described as "very pleasant" "kind" and "caring". One person said of the staff, "They're very kind and do anything you want; they're very friendly and caring, everything's right." A visitor said, "The [staff] are brilliant and very amiable; they don't miss a trick, they know [my relative] very well. The attention to details is very good. I would come here myself. They are very meticulous."

Although people were satisfied with the way they were treated, we found staff did not always meet people's communication needs. Staff attempted to supported people to express their wishes and make informed choices verbally but did not always use visual aids that were available to assist the people who found it difficult to understand the choices offered. For example, we heard a staff member verbally offering meal choices to a person, who had difficulty understanding the options or making a decision. The person asked the staff member to make a decision for them. The staff member replied, "I can't make a decision for you", and then continued to offer the same choices. Photographs of the meals were available and may have helped the person to make an informed choice. On another occasion, a staff member offered another person the option of 'quiche' for their evening meal. The person did not know what quiche was and the staff member had difficulty explaining this to them. Again, they did not use the picture prompts that were available. We raised this with the registered manager, who agreed to discuss this with staff and look into additional communication training.

Staff did not always respect people's privacy. A staff member stood in the doorway of one person's room whilst the occupant was sat in a chair behind them. They were speaking loudly to us about the care needs of another person, whose name they used, which breached their duty of confidentiality. Later, we were led into three people's bedrooms to check pressure settings on people's beds. In each case, the person was in their room, either sat in a chair or in bed with their door open. On two occasions, the staff member entered the room without knocking or seeking permission from the person to enter. We discussed this with the registered manager who agreed to raise the issue of privacy and confidentiality with staff.

Other staff did respect people's privacy. They knocked, explained the purpose of their visit and sought permission from the person before entering their room. When they used the vacuum cleaner, they warned people in advance and apologised for the noise it made. Whilst we were in the lounge, we heard a staff member alert a person in a neighbouring room to our presence, as they had a habit of leaving their room whilst not fully dressed. The staff member said to the person in a quiet voice, "I just don't want you to be embarrassed." We also saw a basket of clothes waiting to be delivered to another person's room; a staff member told us the person was a late riser and they did not want to disturb the person "just to deliver their clothes". On another occasion, when a person dropped a piece of cake on the floor, a staff member picked it up without fuss and discreetly offered the person a new piece of cake. This showed consideration and understanding for people's feelings.

Staff spoke fondly of the people they cared for. A staff member told use that "The people come first; we want

to provide them with a well-adjusted environment and for them to feel that this is their home." Another member of staff said, "We want [people] to feel comfortable, safe and loved."
We observed positive interactions between people and staff. Staff recognised when people became confused or anxious and stopped what they were doing to provide support and reassurance. They made people feel listened to by smiling, bending down to make eye contact and using touch appropriately. They appeared relaxed in each other's company and we heard them talking freely about events from their past or plans for the future. Staff also engaged in gentle banter with some people, who clearly enjoyed it. One person had been born in the same street as a staff member and enjoyed reminiscing together about people and places they had both known. When staff supported people to move or reposition, they did so in a patient, caring way, giving clear instructions and encouragement to the person throughout. Similarly, when people were given medicines, staff were unhurried, they explained what the medicines were for, offered the person a drink, sat with them until they had swallowed them and made sure they were comfortable before leaving them.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to the people's social needs and people did not have access to meaningful activities. One person, who spent most of their day in the same chair, in a lounge where the television was on, told us, "It's awful just sat in the same place every day. You're just bored stiff." Another person said, "It's boring, so I may as well just sleep." A visitor to the home confirmed this and said, "There is a lack of stimulating activities in the home and no effort is made to encourage conversation with and between residents." A staff member had been assigned to arrange activities but had not been given sufficient time to do this. People had been spoken to about activities they wished to take part in, and these were documented, but no action had been taken to arrange them. In February 2016, when the registered manager submitted information to us in advance of the inspection, they told us they were going to organise flower arranging for people who had expressed an interest in doing this. However, this had still not happened. Organised group activities such as 'slide shows' and 'songs of praise' were arranged, but did not always meet people's individual interests and attendance at these was often declined by the people. We discussed the lack of meaningful activities with the registered manager who agreed to review the arrangements for organising them.

We recommend that the provider seek advice and guidance on adopting the latest best practice in respect of providing meaningful activities for older people and those living with a cognitive impairment.

Staff took care to treat people as individuals and tailor their approach according to each person's preferences. Comments from staff included: "Everyone is unique in their own way"; and "[People] may have similar care plans, but everyone is different and that varies the way things are done". Staff demonstrated a good awareness of the individual support needs of people living at the home. They understood how each person preferred to receive care and support. For example, they knew which people needed to be encouraged to drink; the support each person needed with their personal care needs and when people liked to get up and go to bed. One person liked a particular radio station and we heard this playing when we visited their room.

Care plans provided comprehensive information about people, to support staff to provide personalised care in a consistent way. This information had been gained from the person and their family and included people's likes and dislikes, social history and medical conditions. Care plans were reviewed by the deputy manager or registered manager on a monthly basis, or earlier if a person's needs changed. This had helped ensure the care plans remained up to date and reflective of people's current needs. People were supported and encouraged to make choices about day-to day aspects of their lives, including when they got up and went to bed; and how and where they spent their day.

Families and loved ones were able to visit at any time. A family member told us "It's made so easy to visit, you are made to feel so welcome and I can stay as long as I like". Another told us "I am often offered a meal if I visit at lunchtime. The registered manager's door is always open if I have anything I want to discuss". Families told us that they were kept up to date with their relatives needs and wellbeing by the registered manager and one relative said "if anything's wrong they will always phone and update me".

People were also encouraged to remain as independent as possible. Information in care plans explained people's abilities and what tasks they needed support with. For example, one person's care plan stated: "[The person] is able to wash hands and face if handed a flannel" and "[The person] knows his own mind and can choose meals and drinks". We observed staff offered encouragement to people to eat independently by providing assistance to hold cutlery comfortably and positioning food and fluids appropriately to promote independence.

The provider used a key worker system. Key workers are staff whose role was to take a particular interest in a person, spend one-to-one time with them when they could and take them out for a meal on their birthday if no family members were available.

There were systems in place to support people to raise concerns or complaints. People told us they knew how to make a complaint and said they would talk to the staff if they had any issues. One person said, "If I had any complaints I'd go straight to [the registered manager] and she would deal with any concerns." The provider's complaints procedure was clearly displayed within the front entrance of the home, which allowed it to be easily seen by people and visitors. Records showed one formal complaint had been received in the past year; this had been dealt with appropriately and efficiently. The registered manager told us they resolved all minor concerns as and when they arose.

Requires Improvement

Is the service well-led?

Our findings

The systems and processes in place to monitor and improve the quality and safety of the services provided were not always effective. The registered manager had completed a number of audits which highlighted issues or concerns but these were not always acted upon. For example an infection control audit was completed in April 2016 which identified the need for the toilets to be refurbished. An audit of the environment had also identified dangers posed by torn carpets in two people's bedrooms. However, action had not been taken to address these issues. In addition, although medicine audits had been conducted, they had not identified that there was no system in place to account for the quantity of medicines in stock.

The failure to effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified concerns with the quality assurance arrangements, people we spoke with told us they enjoyed living at Firbank and felt it was well-led. One person said, "I like living here; they know what they are doing and the manager is always around to talk to." Another person told us, "[The registered manager] is approachable and well organised."

The home had a clear management structure in place. This comprised the registered manager, the deputy manager and senior care staff. The managers operated an 'on call' rota, so staff could contact them for advice out of hours. Care staff were allocated to individual areas of the home and understood their roles and responsibilities. The registered manager told us they received appropriate support from the provider's representative, who visited the home monthly and was "always at the end of the phone" and would "consider all requests for additional equipment or improvements" that they identified.

Staff told us they enjoyed working at the home and spoke positively about the support and leadership they received from both the registered manager and deputy manager. One staff member said, "[The managers] are amazing. They give us guidance and make us feel valued, which keeps us going. It really feels like a family and we all work well together." Another staff member confirmed this and added, "[The home] is well run and organised. There's a low turnover of staff and we all work well as a team." A third staff member told us, "[The managers] are very supportive. If I have a problem, I just go to them and they always have time for you."

The provider had a set of values they expected staff to work to. These included promoting people's privacy, dignity, choice, and independence. The vision and values of the home were clearly displayed and most staff demonstrated awareness of these. One staff member told us, "The residents will always come first." Another said, "We want [people] to be safe, well looked after and loved."

Staff were kept informed of the needs of the people and management expectations through team meetings, during the staff handovers and through the use of a staff notice board. The registered manager monitored the performance of staff through face to face meetings and observations to ensure they delivered safe and

effective care to people. This also allowed the registered manager to review the day to day culture of the service and the behaviour and attitudes of the staff.
The registered manager told us they hold a resident's and relative's meeting approximately once a month, which allows people and their relative's to put forward suggestions on service development and how they wished to be supported. Where residents were unable to attend these the registered manager or deputy manager provide one to one meeting's with the people to allow their views and ideas to be heard. People, their relatives and the staff had participated in quality assurance questionnaires and the registered manager told us that these were completed annually. The feedback from these questionnaires was generally positive and issues that were raised had been acknowledged by the registered manager.

There was an open and transparent culture at the home. The registered manager was responsive to concerns we identified during the inspection and made arrangements for safety issues to be addressed promptly. Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. CQC were informed of all significant events that had occurred within the home prior to the inspection. However, there were limited and infrequent opportunities to help people keep in touch with, or to access, the wider community other than through family members. We discussed this with the registered manager, who agreed to review and develop their links with community groups.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to effectively assess and mitigate the risks to the health and safety of the people using the service and failed to ensure a clean and hygienic environment. Regulation 12 (1)&(2) (a) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider has failure to protect people from being deprived of their liberty without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance systems and processes were not in place to ensure the safe and effective running of the location. Regulation 17 (1)&(2) (a) (b) (e)