South West Care Homes Limited

The Firs

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

The Firs is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Firs accommodates people across two separate units, both having separate adapted facilities.

The service provides care and support for up to 27 people; some of who may be living with dementia. There were 24 people living at the service at the time of the inspection.

This unannounced focussed inspection took place on 10 and 15 November 2017. The inspection was prompted in part by concerns received about the care provided to people at The Firs. The information shared with the Care Quality Commission (CQC) indicated potential concerns about the management of risk of someone leaving the home who may not have been safe to do so on their own; the management of some behaviours that were challenging to others; staffing levels, staff training with respect to management of risks as well as the management of people's safety. Concerns had also been raised about the cleanliness of the home.

Some of these concerns were not substantiated as we found the home clean. Staff had supported with relevant training. At the time of inspection we found staffing levels were meeting the needs of the people living at the Firs. However there had been occurrences in the previous two months when staffing levels were below the provider's preferred establishment as the number of people living at the Firs had increased.

We had been made aware of an incident where one person, who lacked capacity to go out alone, had left the home without staff being aware. We had not received information about this incident from the provider or registered manager. We found that this incident had occurred and not been reported to the Care Quality Commission or to the local authority safeguarding team.

We found, at the time of inspection, there were sufficient staff to keep people safe. However, there had been a number of days during the preceding months where staffing levels had fallen below the number identified as needed by the provider. Staff understood people's risks and needs and were confident when dealing with the management of specific incidents. We found no evidence to support the concern regarding the cleanliness of the home. However, incidents where a person had shown aggression to another person had not been reported to the local authority safeguarding team or to the CQC as they should have been. Risk assessments had not been reviewed or updated following an incident or accident to reduce the risks of a recurrence.

New staff had been recruited using safe recruitment practices. Checks were made before staff were allowed to work with people.

The team inspected the service against two of the five questions we ask about services: Is the service well

led? and Is the service safe?

A focussed inspection was previously completed in February 2017 to look at safety issues at the service; at that inspection we found the service was safe. The last comprehensive inspection was in September 2016; at that inspection the overall rating for the service was good; however we found that the service required improvement in relation to the question: Is the service responsive? This was because people were not always supported to undertake activities of their choice.

Through our on-going monitoring, and during this inspection, no risks, concerns or significant improvement were identified in the remaining Key Questions, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The service had a registered manager, who was present during the inspection. A registered manager is a person who has registered with the CQC 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 an experienced manager who was working to improve the service and make it more 'dementia friendly'.

People, relatives and staff were all very positive about the registered manager and the improvements she had implemented since she had started in the home in July 2017. People and staff had been consulted about the improvements which had led to a more 'dementia friendly' environment. People were also being supported to have choice about meals, snacks and drinks.

The home was, clean, well maintained and generally safe. Staff followed good infection prevention and control practices.

Incidents and accidents were reviewed by the registered manager, but this had not always led to a full consideration of how to reduce the risks of recurrence. The registered manager had failed to notify us about significant incidents including safeguarding concerns.

We have made one recommendation in relation to the monitoring of safety at the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were occasions when people were not fully protected against the risk of abuse and people did not always receive safe care. We also found a breach of the Care Quality Commission (Registration) Regulations 2009 as the registered manager had not notified the CQC of incidents that had occurred.

You can see what action we told the provider to take at the back of the full version of the 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 fully safe.

Risk assessments had not been updated when a person's risks or needs changed.

At the time of inspection there were sufficient staff, but records showed that there had not been sufficient staff at all times during preceding months.

Medicines were stored, administered and recorded safely.

People were at risk because risks to people's health and safety were not always effectively managed to reduce risks of avoidable harm.

The environment was clean, odour free and well-maintained.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led

The service had not submitted statutory notifications to the Care Quality Commission when particular events had occurred.

Checks and audits were carried out routinely but these had not always identified issues that were found during the inspection. However the registered manager and provider were making improvements to this.

There was a registered manager in post who was liked and respected by people and staff

The registered manager encouraged people and staff to get involved in improving the service.

The Firs

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 10 and 15 November 2017. The inspection was undertaken in response to concerns raised with the Care Quality Commission (CQC) in relation to staffing levels at the service; staff training, cleanliness of the home and the management of risks.

The first day of inspection was unannounced and carried out by two adult social care inspectors. On the second day, one of these inspectors returned with another inspector.

Prior to the inspection we reviewed information we held on our systems. This included reviewing whether any statutory notifications had been submitted to us. A notification is information about important events which the service is required to tell us about by law.

During the inspection we spoke with five care staff, two kitchen staff, as well as the registered manager and the provider. We also spoke with two operational managers who work with The Firs as well as the provider's other services.

We met most of the people living at the Firs and spoke with three of them. We also spent time observing the care and support delivered. During the inspection we looked at staffing rotas for September and October 2017; staff training and induction records, three staff files and five people's care records including risk assessments, care plans and daily notes. We observed a medicine administration round and looked at medicine administration records. We also reviewed the storage of medicines.

After the inspection we spoke with one social care professional.

Requires Improvement

Is the service safe?

Our findings

We inspected this key question to follow up concerns we received about the safety of people. These concerns included insufficient staffing to support people safely as the number of people living in the care home had increased in recent months; staff not being suitably trained to manage people who were at times verbally and/or physically aggressive; the cleanliness of the home and the management of risks to people.

We found that there had been occurrences when staffing levels were below the provider's preferred establishment as the number of people living at the Firs had increased. There was no evidence to support the concerns that staff had not been trained to support people in a safe way. We also found no evidence to support the claim the home was unclean.

We had also received information about a particular incident which had occurred on a Sunday afternoon in September 2017. A person living with dementia, who staff had assessed as lacking capacity to remain safe when out alone, had left the home without staff's knowledge. They had exited the home through a door at the back of the building and then through an unlocked garden gate. The person was picked up by local people who took them to the local hospital. Staff confirmed they were not aware the person had gone out and it was only when the hospital called the home that staff became aware the person was missing.

A mental capacity assessment had been undertaken at the end of June 2017 to determine whether the person was able to go out on their own safely. It determined they did not have capacity to make a decision about going out alone. It described the least restrictive actions as 'being supported to obtain /distracted if at an unreasonable time.' A risk assessment on the person's use of the garden stated that the person should be supervised when walking in the garden and door alarms were on outer doors to alert staff if a person was going into the garden. It also stated that if the person wished to sit in the garden, staff were to monitor every 15 minutes. The residual risk if the actions were followed was low.

The person's care plan also stated that they had shown 'no signs of depression or anxiety in the past. There was also no mention of any anger or aggression in the person's risk assessment or care plan. However, daily notes described how the person had been very agitated and showing signs of being depressed.

Records showed that the person had been very agitated throughout the day they had left the home. Staff had written up three sets of information in the daily notes, all of which described in detail how the person was very upset and wanting to go home. Notes showed they had been 'demanding to get out all afternoon'. They had also been aggressive to other people and staff. Staff were not aware that they had left the home. One staff member said they were monitoring this person every 15 minutes or so but the risk assessment did not specify this or guide staff about an agreed strategy. Other staff said they "kept an eye on this person" but no-one was clear of the strategy to monitor her whereabouts. One staff member on duty at the time of the incident said "That day there were only three of us on – it was busy that day – manic. I saw [person] at tea time … We were busy up and down and with the bells."

A record later in the day, after the person returned to the home, described how they tried to leave the home

again using the same back gate, but staff were able to intervene. Records showed 'luckily we were watching her'. They recorded that they took remedial action where they suggested the person went to her room and settle. The risk assessment and care plan for the person had not been updated to reflect the incident. In the care plan, it stated that the person could be confused and wanting to go home. It also stated that the person had not made any purposeful attempts to leave the home. No new actions to mitigate risk had been identified.

We discussed how care plans and risk assessments were updated with the registered manager; they said they did reviews of risk assessments and care plans on a monthly basis, but did not update risk assessments or care plans if a person's needs or risks changed during the month. For example, during one month, one person had three falls, two of which resulted in an injury. However, their falls risk assessment and care plan had not been reviewed to consider whether there were ways to further reduce the risk of future falls. It had not been identified that one radiator did not have a cover to prevent the risk of burns. It had not been identified that one person's care plan had not been reviewed since an incident when they had left the home unnoticed.

Some risks to people were not always considered. For example, the registered manager had reported to the provider that an external door keypad was not working properly. The provider arranged for repairs which were carried out six days later. However, during the intervening period, the incident where the person left the building via this door without staff knowledge occurred. No short-term safety measures had been put in place to reduce the risks until the repair was carried out. Following the inspection, the provider said that pending the fitting of a new keypad, the home's maintenance man had checked the door to ensure it was locking and unlocking.

Although incidents and accidents were reviewed by the registered manager, they had not always considered fully how to reduce the risks of a similar occurrence happening. After the incident of the person leaving the home, the registered manager introduced additional security checks when the night shift came on duty to ensure the premises were secure. They said that the doors alarms were all now working, but they expected night staff to check the garden gate was locked. They explained that the gate had been left unlocked by night staff after they had opened it for an ambulance the preceding night. We discussed the new measures with the registered manager as the checks on the gate were scheduled during the evening although the incident had occurred in the afternoon. No checks had been put in place to check the gate during the day. This meant that a similar incident could still occur. The registered manager said they would review the procedures to ensure checks were carried out at the start of each shift.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection, we found safeguarding issues had not always been recognised and appropriate referrals had not been made when incidents involving abuse or alleged abuse had occurred. Records showed, and staff confirmed, there had been five incidents at the service, which involved physical and/or verbal aggression between people between 1 September and 10 November 2017. Four had not been reported to the safeguarding authority or to the Care Quality Commission. The incident where the person had left the home unobserved had also not been reported as a safeguarding incident although the person was vulnerable.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had made a referral to the local mental health team for a reassessment of one person who, at times, displayed aggression and one person's medicines to be reviewed. Their medicines had been reviewed and adjusted to help manage their aggression and anxiety.

Staff had received training relating to safeguarding which included what they should do if they had concerns about people being abused. They were able to describe types of safeguarding issues and were aware of how to report concerns, including to external agencies. A social care professional commented that they had "no concerns."

Risks for each person had been assessed when they first started living at the Firs. Assessments included: the personal care they needed support with; emotional support; their medicines and the administration of these; their mobility and risk of falls; the risks in relation to maintaining good nutrition and hydration; skin integrity and ability to make decisions including going out alone.

Each person's risk assessments were reviewed and updated each month by the registered manager. However, risk assessments were not always reviewed when a significant change or event for the person had occurred. This meant there was a risk that people would not receive the right care and support needed to keep them safe between when the change occurred and the date each month the assessments were reviewed. For example, where a person had had a fall which resulted in an injury, the risk assessment had not been updated immediately after the fall to address any changes in the person's mobility. There had been no reassessment of what support should be provided to reduce the risk of the person falling again. An assessment or risk assessment to support the person to maintain their independence had not been completed or considered. The person fell two further times within a week of the initial fall.

The registered manager said that, in future, they would update risk assessments following incidents, accidents and changes in people's presentation.

Staff were aware of the risks people presented in relation to their health; mobility and behaviours. They said care records contained a good level of detail to guide them and that any changes were discussed at handover. They described how they tried to reduce incidents between people by encouraging people to use different areas of the service. They used distraction techniques and supported people when they became anxious or restless. For example, during the inspection one person attempted to leave the building via a garden door. Staff immediately intervened; they engaged with the person and with gentle persuasion they got the person involved in an activity.

Staffing levels had not always been sufficient to meet people's needs and keep them safe. The provider used a tool which helped them determine the number of care staffing hours needed to support people with a calculated level of dependency between one and four. For example, based upon 23 people with differing levels of dependency, the tool had calculated that during the day, four staff including a team leader and three care workers were needed.

The registered manager explained that there had only been 14 people living at the home during the summer 2017 and therefore staffing levels had been reduced to one team leader and two care staff. However, they said that the number of people had increased since July but the staffing ratios had not increased until later. The registered manager explained the preferred staffing levels had increased from one team leader and two care staff between 7am to 7pm to one team leader and three care staff between these hours. However, a review of the rotas showed there were 11 shifts between 21 October and 6 November 2017 when the staffing ratio did not meet the levels indicated by the provider's dependency tool. The provider and registered manager said that whilst some of the shortages had been due to unplanned staff sickness, there were also

some shifts when there were insufficient staff as they had not recruited fully. There had been a delay between the increased number of people living in the home and the recruitment of new staff. New staff were now in place.

In addition to care staff, a cook and housekeeping staff worked every day. The registered manager usually worked during the day, Monday to Friday. However, they also covered care shifts when necessary. The registered manager had recently worked a night shift recently due to staff absence. Staff said the registered manager was flexible and they appreciated their approach.

On the days of inspection, the staffing levels were at the provider's preferred levels given the number of people and the level of their needs. The provider and the registered manager confirmed that preferred staffing levels were now being maintained. During the inspection there were four members of staff on duty along with the registered manager. The atmosphere was calm and unrushed. People's needs and requests were met in a timely way and staff had time to support people with social activities, such as painting and arts and crafts. One person said staff were usually visible and responded quickly to requests for assistance. They added, "I have enjoyed my stay here. I can't grumble about anything. Staff are very good; nothing is too much trouble for them. I feel safe here; nothing frightens me." Another person added "There's always someone to hand." A relative said they were pleased with the care and support their family member received. They said, "They (staff) are very nice and seem to have plenty of time for you."

Staff said the increase in staffing levels had been welcome. One said, "When we have our four staff then we have time to sit with people; spend time with them. It makes a difference." Another said, "[The registered manager] increased staffing which was great. If we have only three on due to sickness then we all work together. [The registered manager] is fantastic and will help on the floor if we are one short. It is busy but we manage." Another care worker said, "It can be a rush at times (with three staff) but we try not to rush people."

Concerns were raised with CQC that new staff did not receive induction training to ensure they worked safely with people. We did not find evidence to support these concerns. One new member of staff had completed two shadowing shifts, working with senior staff to help orientate them and familiarise them with people's individual needs. This member of staff had also completed safeguarding training; moving and handling training and fire safety awareness before working as part of the team. Their induction was on-going and the registered manager explained the Care Certificate was completed by staff new to care. The new member of staff said they felt well supported by the manager and team and were not asked or expected to undertake duties they did not feel confident to do. They said, "I really like it here. Other staff are very supportive…"

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. For example, information on file included a completed application form; full employment history; two satisfactory references and a satisfactory Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have and helps employers make safer recruiting decisions to ensure people were not exposed to staff barred from working with vulnerable adults.

We had received concerns that the home was not clean and hygienic. We did not find any evidence to support this during the inspection. The service was clean with no unpleasant odours. Housekeeping staff were employed to maintain hygienic standards. Staff confirmed there were always sufficient supplies of protective equipment such as gloves and aprons. Bathrooms and toilets contained liquid soap and paper towels to promote hand hygiene and prevent any infections.

Staff managed medicines safely and consistently. Staff had a good knowledge of the medicines people were prescribed and had received training in the safe handling of medicines. Records were clear and contained all the necessary information, including known allergies and a photo of the person. All hand written entries were countersigned by two staff. Medicines audits were completed on a regular basis. All medicines were stored securely. Staff gave very clear explanations to the person they were giving medicines and stayed with them until they had finished taking them. Where people had several medicines to take, the member of staff took their time not to rush people and to let them take them at their own pace. They offered gentle support and encouragement such as "Almost gone, just two to go now. Are they going down okay?" One person did not want to take their medicines and this was recorded on their medicines chart.

Requires Improvement

Is the service well-led?

Our findings

We had not received statutory notifications about events and incidents at the service, such as safeguarding issues. This meant we were unable to monitor the service effectively.

There were five incident records between 1 September and 7 November 2017 where the registered person should have notified the Care Quality Commission (CQC). These included incidents where a person had been aggressive to another person living in the home.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had a governance framework which monitored the quality of the care provided. However the systems to assess and monitor the safety and quality of the service had not identified, or fully addressed, the issues that we found during our visit. . The registered manager said that a senior manager undertook a visit to do an audit every three months. Half the audits were announced while the others were unannounced. The registered manager said that during the visits, the audit would review the quality of the service. The audit took into account, people's feedback as well as the quality and safety of the premises. The audit also reviewed care records. However these audits had not identified risk assessments were not being updated when people's need changed.

The registered manager said that they were planning in future to implement more timely reviews of people's risk assessments and care plans following incidents and accidents. They said they had appointed a senior care worker who would be able to support them in this.

Information in people's daily notes was not used to analyse whether they were receiving the care they needed. For example, one person's care plan described how the person required a minimum of two litres of fluid each day. Staff had entered how much the person been offered and had drunk each day. However this information had not been reviewed to see if the person was consuming the required volume of fluids. There had been days when the person had not been offered or received the recommended amounts. We discussed this with the registered manager, who said the information was not analysed to ensure the person was kept hydrated. They said that they were working with staff to ensure they used the system to record information more accurately as in the past, staff had entered that everything that had been offered to a person had been drunk. They said they would take steps to ensure that in future staff monitored that the person was consuming sufficient fluids.

The secure computer system used to record people's risk assessments, care plans and daily notes as well as incidents and accidents provided readily available information for staff. Staff had to confirm that they had read hand-over notes when they commenced a shift. This meant they were kept aware of changes in people's needs. The computerised information could be used to analyse data to support improved care. For example, reports were produced which showed the number of falls/accidents each month. Analysis of this information can support the introduction of ways to reduce these types of events either for a particular person or for a group of people. However, it was not clear whether the information had been used to do this

or how the success (or otherwise) of interventions was being measured.

Senior staff from the provider organisation visited the home regularly. These visits included monthly review meetings carried out by senior staff from the provider's operational team. A three monthly review meeting which included supervision for the registered manager was also conducted by the operational team staff as well as the nominated individual. Records showed, and the registered manager confirmed, that a three monthly review had been completed in November 2017. The review covered a number of areas which included: staff training; staff supervision; care plans; medication; maintenance; infection control; staffing; recruitment; health and safety, and progress on the dementia action plan. Each area was given a traffic light rating of green, amber or red. One area related to infection control had been rated as amber, which indicated there were actions that were late/outstanding beyond their planned date. This was because the infection control audit and the associated action plan undertaken in June 2017 had not been reviewed. A deadline for the registered manager to achieve this was set for 20 November 2017. All other areas the November 2017 review recorded as green, which indicated that satisfactory progress/levels were being met.

We recommend the provider reviews their system and process for monitoring the safety of the service.

The quality assurance system included gathering feedback through resident and family meetings which were held monthly. The registered manager explained that, as these were not always well attended, they also made sure they spoke to each person as well as family members. People and visitors were also encouraged to provide verbal and written feedback. For example, recent comments had included 'Thank you for taking care of our good friend [person's name] and for making us feel so welcome when we visited.'; 'Lovely atmosphere, lots going on for residents' and 'Good improvements to the home.'

Positive progress was recorded in some areas of the service, including making improvements to support people living with dementia. The audit also identified that a recent pharmacist audit had gone well. The commentary for other areas showed that there were areas for improvement, for example the section entitled 'training' identified that the current score was 59%, which had 'dropped back from previous matrix due to a combination of some new staff and some training out of date. This demonstrated that the provider and registered manager were aware of the need to monitor systems and ensure that improvements were planned and carried out.

A new manager had been registered with the CQC since the last inspection. The registered manager had previously managed another home owned by the same provider for several years. This meant they had experience of running a care home. Staff spoke very highly of the registered manager and described several improvements made over a short period of time since her arrival. For example, staff felt the registered manager had brought "stability" to the service. One said, "We have had several managers over the past few years, so lots of changes. The changes unsettle us. But (registered manager) is a breath of fresh air. She is always available to support us; she has increased staffing levels, she works on the floor with us…morale has improved and we are happier…" Another staff member said, "Since (registered manager) been here there have been unbelievable changes…she is making it better for everyone…we are happier and our confidence is better. She values us; we are more organised; the premises are cleaner…"

The registered manager and staff worked with other agencies to support people's care. Records showed that there was contact with social care managers, GPs and health professionals to ensure people received appropriate care and support.

The registered manager described how they were keen to introduce improvements to the home to support

people living with dementia. Some improvements had already been implemented to enhance the environment; these included a 'café' area in the conservatory where people and their visitors could help themselves to drinks and snacks. Snacks had been made freely available, including fresh fruit, biscuits and chocolate bars; we saw people eating these snacks during the inspection. People also used this refurbished area for various activities including arts and crafts.

The registered manager had involved people in the redesign of the home. For example, people had helped to choose the theme for the dining room. People had chosen to have it decorated in the style of an 'American diner' with checker tablecloths, cupboard doors decorated to appear like a juke box, brightly patterned wallpaper and a record player. People's mealtime experience had improved as staff took examples of the meals on offer to each person to help them decide what they would like to eat. Staff reported that this had resulted in a reduction of food waste and that people were enjoying their meals more.

The registered manager was open and helpful providing all requested information promptly. They were visible in the service and it was clear both people and staff were relaxed and comfortable in their company.

The registered manager sent us a copy of their dementia action plan to show the progress they had made and how they were also looking to improve other areas. This included improving the outside environment at the front of the home, making further adaptations to another conservatory to have a 'trip to the seaside' theme and create a sensory 'quiet area' garden.

Staff confirmed meetings took place which provided them with an opportunity to discuss any issues, concerns or raise suggestions. Staff said they felt their views were listened to by the registered manager and she responded promptly to requests. For example, requests for personal care products and supplies were dealt with immediately. One member of staff said, "We are a happy team here with (the registered manager)." All staff spoken with said they enjoyed their jobs and gained "great satisfaction" from their role.

The provider's website described their vision and values which included 'We believe in the importance of choice… It is by making choices in our lives, by controlling our own destiny, that we are independent, that we have self-respect….we create a relaxed and happy atmosphere. We understand that people value their privacy and independence, yet appreciate the benefits of companionship and the reassurance that help is on hand if needed.' Throughout the inspection, the registered manager and staff at the Firs were able to describe and demonstrate these values.

The registered manager was working towards improving integration into the community for example by making the front garden more accessible for people living in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The Care Quality Commission had not received notifications about safeguarding incidents which had involved people living in the home. 18(1)(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans did not always fully reflect people people's risks and needs when changes occurred. When incidents had happened, plans did not always take into full consideration how to reduce the risks of recurrence. 12(1)(2)(a)(b)

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 Safeguarding issues had not always been recognised or reported to the appropriate agencies such as the local authority safeguarding team. 13 (1) (2)