Eldahurst Limited

The Firs Rest Home

Inspection report

141 Malvern Road
St Johns
Worcester
WR2 4LN
Tel: 01905 426194

Date of inspection visit: 7 October 2015
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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 April 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to safeguarding service users from abuse and improper treatment, regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We undertook this focused inspection on 7 October 2015 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Firs Rest Home on our website at www.cqc.org.uk

The Firs Rest Home provides accommodation and personal care to a maximum of 15 people. There were 15 people who lived at the home at the time of our inspection.

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.

At our focused inspection on the 7 October 2015, we found that the provider had followed their plan which they had told us would be completed by the 31 July 2015 and legal requirements had been met.

People told us they felt safe in the home and that they had no concerns. Staff we spoke with knew how to protect people from harm. Staff told us about different types of abuse and knew how to report this where necessary. When an incident had happened the appropriate external agencies had been contacted.

While we found there had been positive improvements in people's experience of care. We could not improve the

Summary of findings

rating for safe from requires improvement to good. This is because to do so, the provider is required to demonstrate consistent good practice over time. We will check this during our next planned comprehensive inspection.

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?
People were cared for by staff who had the knowledge to protect people from the risk harm.

We could not improve the rating for safe from requires improvement, because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement

The Firs Rest 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.

We undertook an unannounced focused inspection of The Firs Rest Home on 7 October 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 14 April 2015 inspection had been made. We inspected the service against one of the five questions we ask about services: is the service safe? This is because the service was not meeting some legal requirements.

The inspection was undertaken by one inspector.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with three people who used the service. We also spoke with two staff, the administrator and the deputy manager. We reviewed the provider's process for reporting potential safeguarding incidents and one person's care file.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of The Firs Rest Home on 14 April 2015 we found that staff did not have full understanding of different types of abuse. For example, verbal abuse or unexplained bruising. We found that the registered manager did not recognise incidents that were reported to them by the staff members as potential safeguarding matters. These were therefore not reported to the Local Authority and the Care Quality Commission where necessary.

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

At our focused inspection on 7 October 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of regulation 13 described above.

We spoke with the deputy manager to understand what changes had been made since our last inspection. They told us that all staff had received further training in safeguarding vulnerable people. They went onto say how they now recognised when to report incidents to the local authority where necessary. The deputy manager provided a recent example of what had been reported to the local authority as a potential safeguarding. They showed a good understanding of different types of abuse and what incidents would be raised with the local authority. There had been one safeguarding incident reported to the Care Quality Commission (CQC) prior to this inspection and we found that the registered manager had followed the correct procedures to ensure people were kept safe.

We spoke with people about if they felt safe living in the home. One person said, “I’m very comfortable here, the staff help me if I need anything”. Another person said, “It is fine here, I have nothing to worry about”.

We spoke with staff about how they protected people from harm. Staff told us that they had received further safeguarding training. They told us this training gave them the opportunity to discuss situations that were individual to the people who lived there. Staff shared examples of how they reduced the likelihood of incidents from happening. For example, how they used distraction techniques to help calm a person who may be becoming distressed towards another person. They told us that this often worked however when incidents did happen these were recorded and reported to people in a management position. Staff were aware of external agencies to contact, should they be required to report a potential safeguarding incident themselves.

While we found there had been positive improvements in people’s experience of care. We could not improve the rating for safe from requires improvement to good. This is because to do so, the provider is required to demonstrate consistent good practice over time. We will check this during our next planned comprehensive inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.