Care West Country Limited

# The Firs Nursing Home

## Inspection report

251 Staplegrove Road
Taunton
Somerset
TA2 6AQ

Tel: 01823275927

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
The Firs Nursing Home is a care home providing nursing and personal care to up to 40 people. The home specialises in the care of older people but is able to cater for some younger people who have physical nursing needs. At the time of the inspection there were 31 people living at the home.

People's experience of using this service and what we found
People were not always supported by adequate numbers of staff to meet their needs and keep them safe. The provider used a dependency tool to assess hours required to meet people's needs but on a number of occasions the home was not staffed to the assessed level.

The senior management team were not always working together to create an inclusive atmosphere and ensure there was a consistent plan to achieve improvements to the service provided. Some staff felt undervalued and this had led to poor staff morale which did not always create a happy and relaxed atmosphere for people to live in.

People did not always benefit from a clean and hygienic environment. The monitoring of infection prevention and control practices was not robust which could place people at risk of harm.

Since the last inspection there had been some improvements in how quality was assessed and monitored but this did not always lead to improvements in people's quality of life. However, relatives spoken with felt there had been a number of improvements in the home.

People felt safe at the home and with the staff who supported them. People looked relaxed when staff supported them and told us they were always treated with kindness.

People received their medicines safely from registered nurses or senior staff who had received specific training to carry out the task. Clear records were kept of all medicines administered or refused which enabled staff to monitor the effectiveness of prescribed medicines.

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

Rating at last inspection The last rating for this service was requires improvement (published 14 August 2019)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made, or sustained, and the provider was still in

breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 17 and 18 July 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. Breaches identified related to Regulation 12 (safe care and treatment) Regulation 17 (Good governance) Regulation 18 (Staffing).

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. At this inspection we found the provider continued to be in breach of regulations.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Firs Nursing Home on our website at www.cqc.org.uk.

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

We have identified a breach of regulation in relation to safeguarding service users from abuse and improper treatment at this inspection.

Please see the action we have told the provider to take at the end of this report.

We also identified continued breaches in relation to staffing, safe care and treatment and good governance.

We have added conditions to the provider's registration for this location.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not always safe | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not always well-led. | **Requires Improvement** |

# The Firs Nursing Home

**Detailed findings**

## Background to this inspection

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

This was a focussed inspection which only looked at the key questions of safe and well led.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors on site and an Expert by Experience supported us remotely by making phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was announced.

We gave a short period notice of the inspection because we wanted to ensure the safety of people, staff and the inspectors in light of the Covid 19 pandemic.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We asked for some information to be sent to us before the inspection to reduce the time the inspectors needed to spend at the home. Information requested included some audits, records of staff training and minutes of meetings. All information requested was received.

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

We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service. We spoke on the phone to 14 relatives about their experience of the care provided. We spoke with 10 members of care and ancillary staff. The registered manager was available throughout the day and we were able to speak briefly with the nominated individual. 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.

We reviewed a range of records. This included two people's care records and a sample medication records.

After the inspection
The provider sent us a copy of the provider visit report and actions to be taken to address issues identified.

Requires Improvement

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At the last inspection we found there were not always sufficient, suitably skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (Staffing) and regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified similar concerns. Not enough improvement had been made and the provider is still in breach of regulation 18 and regulation 12.

- People were not always supported by sufficient numbers of suitably skilled and experienced staff to meet their needs. The provider used a dependency tool to calculate the staffing levels required at the home. For the occupancy level at the time of the inspection, this calculation equated to seven care staff each morning, five each afternoon, one twilight shift and two care staff overnight. The registered nurse and nursing assistant hours were in addition to this. Rotas seen showed in the last 14 days there had been eight occasions when this staffing level was not met. The registered manager informed us that there had, on occasions, been difficulty sourcing agency staff to cover last minute sickness and staff personal emergencies, which had led to the shortfalls. They were currently recruiting additional staff.
- People did not always receive the care they required because of a lack of staff to support them. For example, one person required staff supervision to be safe in communal areas of the home. When this was not available their care records showed they were often put into bed which was not in accordance with their wishes. One person told us, "Activities start at 10.30, if they [staff] haven't had time to help me dress I have to miss them."
- Call bells were not always answered promptly meaning people had to wait for assistance when they requested it. We heard call bells ringing throughout the day and saw on the home's monitor that one bell had been ringing for over 21 minutes before we highlighted this and it was responded to. One person told us, "I have to wait a long time when I call for help. Sometimes I have to wait over 20 minutes, even more at night. Sometimes it is too late when they do get here".
- Staff felt they often could only provide people with basic physical care which meant missed out of social stimulation. One member of staff said, "We often just don't have time to just sit with people."
- People were supported by staff who had been checked as safe to work at the home. There had been no changes to the recruitment process since the last inspection and staff did not start work until appropriate checks had been received.

This is a breach of Regulation 18 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risks of abuse and improper treatment. Staff had received training in recognising and reporting abuse. However, one person was subject to some restrictions which they were not able to consent to and had not been assessed as being in their best interests. The practices being used for this person had not been identified as restraint by the registered manager or staff team. There was no assessment to demonstrate that the restraint used was proportionate to the risks to the person, and no less restrictive measures had been explored. Following the inspection we made a referral to the Local Authority safeguarding team to make sure this person was cared for safely.

This is a breach of Regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People felt safe at the home and with staff who supported them. People told us staff were always kind to them and people looked comfortable and relaxed with the staff who assisted them.
● Relatives we spoke with felt their loved ones were kept safe. One relative said, "It's a big worry off our minds with her being there, we know they are safe."

Preventing and controlling infection
● People were at risk as the service was not meeting current national guidance and standards in regards infection prevention and control. We were informed that there was reduced housekeeping staff due to Covid 19 and reduction in some cleaning hours. Staff informed us they were concerned in regard the cleanliness of the home and said that on some occasions there were no cleaning staff available over the weekend. We found that some areas, including communal bathrooms, required further cleaning to ensure they were hygienically clean and minimised the risks of the spread of infection.
●We were not assured that the provider's infection prevention and control policy was up to date. We discussed with the registered manager that their infection control audit needed to take into account current Covid 19 pandemic national guidance.

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

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● Although lessons were learnt when things went wrong, changes needed were not fully embedded in practice to make sure there were improvements to people's care. For example, the oversight of monitoring records, such as food and fluid charts, had been raised at the last inspection. We were assured that all food and fluid charts were checked daily by a senior member of staff to ensure action was taken when needed. But at this inspection this was not routinely being done.

Assessing risk, safety monitoring and management

● Risks to individuals were assessed and measures were put in place to minimise these risks. For example, where people were assessed as being at high risk of pressure damage to their skin staff assisted them to change position regularly to minimise risks.

● There was a lack of oversight in the management of risk. For example, some people were at risk of dehydration and charts were in place to monitor the amount they drank. Although charts were completed by care staff no one checked each day to enable them to take action if the person did not drink sufficient fluids.

● Environmental risk assessments were not always clear so did not fully protect people. The registered manager and nominated individual told us a fire risk assessment had been carried out in 2014 and was reviewed annually by an outside contractor. The original risk assessment was not available. The annual review was available but shortfalls highlighted on review did not show whether action had been taken to rectify the identified shortcomings. The nominated individual gave assurances that a full fire risk assessment would be commissioned and implemented.

Using medicines safely

● People received their medicines safely from trained staff. Clear records were kept of when medicines were administered or refused. Where medicines were repeatedly refused, the nursing staff liaised with other professionals to promote the person's choice and well-being.

● Some people were prescribed medicines, such as pain relief, on an 'as required' basis. There were protocols in place to ensure all staff administered these in a consistent way.

● People had access to pain relief at the end of their lives to promote their comfort and dignity. Registered nurses ensured that appropriate pain relief was prescribed and available to people when people were nearing the end of their lives.

Requires Improvement

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection we found the provider did not have effective systems in place to manage the home or to monitor and improve the quality of the service provided to people. This is a beach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that although some improvements to quality monitoring systems were in place, they had not yet been effective in improving people's care and support. Not enough improvement had been made and the provider is still in breach of regulation 17.

● We acknowledge our inspection took place during the Covid 19 pandemic. It was evident the pandemic has had a significant impact on the pace of improvement within the service. The provider had not been able to carry out monitoring visits regularly but did complete one the same day as the inspection. We were able to speak briefly to the nominated individual at the end of their visit. Their audit, and discussions with staff, identified similar issues to those identified by us at this inspection.
● The management of the home was re-active rather than pro-active. The registered manager was very open to our feedback but although some issues were already known to them, they had not taken action to address them. For example, we highlighted that there was a high number of people being cared for in bed. The registered manager acknowledged some people in bed may benefit from more assistance and social stimulation but had not taken any action.
● Audits undertaken did not always lead to improvements for people who lived at the home. For example, the call bell audit from 1 July 2020 to 8 September 2020 informed us that there had been 1676 calls that had not been responded to for over 10 minutes. The registered manager informed us, "I am aware there is a high use of call bells, I am looking at the system. I remind staff to ensure they answer. I did receive one complaint from a resident in regards a long wait at night. We apologised."
● Infection control and prevention audits were not robust in ensuring that the spread of infection was minimised. The last audit was carried out in April 2020 and no further audits had been carried out which considered the Covid 19 pandemic. During the inspection we found additional PPE stations were not in place to make sure staff had easy access to this at all times. Before the end of the inspection additional facilities had been arranged. There was a lack of cleaning staff and cleaning schedules had not been enhanced to ensure additional cleaning of touch points.

This is a breach of Regulation 17 (Good governance ) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Relatives spoken with felt that there had been improvements in the home since the registered manager took up post over a year ago. One relative said, "It has completely changed for the better." Another commented, "It's much improved recently. I've seen it at it's worst and this is so much better."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture in the home at the time of the inspection did not always promote a happy and relaxed atmosphere for people to live in. Staff told us, although they were committed to supporting people, they often felt stressed by lack of staff and other pressures. One member of staff said, "We try to give people the best care we can. We really do care about them, we are stressed out because we are short staffed".

● The senior management team were not always working together to create an inclusive atmosphere and ensure there was a consistent plan to achieve improvements to the service provided. Staff felt that communication from the provider was poor and they often felt undervalued as a staff team. One member of staff said, "Morale is very low. Everyone fears the senior management." Another member of staff said they felt "Fearful of raising things with [nominated individual's name.]"

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People lived in a home where the registered manager was open and approachable. One relative said, "I'd talk to [registered manager's name] if I had a problem, she's friendly and approachable." One person told us, "[Registered manager's name] is a lovely lady she puts herself out for everyone."

● The registered manager shares information appropriately with other professionals to ensure people receive the care and support they require.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Relatives felt informed about what was happening at the home and said that the staff communicated well with them. Some praised how staff had helped them to keep in touch with their loved ones during the pandemic when visiting had been difficult. One relative said, "They always keep me informed." Another said, "I'm delighted at the early lockdown, it has all been positive although stressful. Whatever they have done it has been fantastic."

● People were supported to keep in touch with friends and family although they were having to adapt to new ways of keeping in touch, such as garden visits and video calls.

● Staff did not always feel involved in the running of the home and at times felt their views were not listened to. One member of staff said they had raised issues but had not felt listened to.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not always protected from the use of restraint that was not fully assessed as being proportionate to the risk of harm posed to a service user.<br><br>Regulation 13 (4) (b) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider was not always ensuring that people were fully protected by the homes infection prevention and control practices.<br><br>Regulation 12 (2) (h) |

**The enforcement action we took:**

We have added additional conditions to the locations registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The quality assurance systems were not always effective in ensuring shortfalls were identified and addressed to improve the quality of care people received.<br><br>Regulation 17 (1) (2) (a)(b) |

**The enforcement action we took:**

We have added additional conditions to the locations registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not always ensured there were sufficient staff to meet people's needs.<br><br>Regulation 18 (1) |

**The enforcement action we took:**

We have added additional conditions to the locations registration.