South West Care Homes Limited

The Firs

Inspection report

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Witheridge
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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service because of an incident at the service which was being investigated by the police. We wanted to ensure people at the service were safe so looked at the actions taken by the provider following the incident and at how risks were managed at the service. Following the inspection we were made aware that the police were taking no action regarding the incident.

The Firs is registered to provide accommodation for people who require personal care. The service provides care and support for 27 people; some people are living with dementia. There were 19 people living at the home at the time of the inspection.

We carried out an unannounced comprehensive inspection of this service on 2 and 6 September 2016. At that inspection we judged the service rating to be overall good, but required improvement in the responsive domain. All other domains were rated as good. We had made a recommendation that the service sought advice and guidance on developing activities for people living with dementia.

There was a manager at the service who had started the application process of registering with the Care Quality Commission (CQC) to become the registered manager at the service. 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 provider had considered on-going possible risks to people. At the inspection we were made aware by the director and through a statutory notification submitted to CQC, about the actions they had taken. These actions did not relate directly to the incident but had been identified as sensible safety enhancements. Following the inspection the director confirmed that the actions had been carried out. They also confirmed alarm checks had been added to the weekly maintenance checks. The manager and deputy operations manager had been working on updating the service's environmental risk assessment.
Accidents and incidents were safely managed. Staff had recorded incidents and accidents on the provider's computerised system and the actions they had taken. The manager was well informed about incidents and accidents at the home and looked for trends and patterns.

People's risk assessments and care plans were detailed and gave staff instructions about how to manage and reduce risks.

The director and the deputy operations manager had been at the service since the incident to liaise with all involved. They were also supporting the manager and staff to continue with their roles to provide a service to the other people at the home.

This report only covers our findings in relation to these topics. You can read the report from the last comprehensive inspection by selecting the 'all reports' link for The Firs on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments had been amended following an incident.

Environmental checks were in place. These were added to following an incident.

Accidents and incidents were safely managed.

People's individual risk assessments and care plans were detailed and gave staff instructions about how to manage and reduce risks.

The Firs

Detailed findings

Background to this inspection

We carried out this focused 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.

We undertook an unannounced focused inspection of The Firs on 2 February 2017. This was in response to an incident and we needed to check about the safety of people living at the home. An inspection manager and inspector visited the service to check on the safety and welfare of people following the incident. The inspection team looked in detail at one of the five key questions we ask about services: is the service safe?

Prior to the inspection we gathered and reviewed the information we held about the home. This included looking at the previous inspection report, action plan, notifications and all previous contact we had about the home, including all documents sent to us.

The manager showed us around the ground floor and the garden. We looked at the outside area and looked at security at the home and the changes made following the incident.

We spoke with the manager, the director and the provider's deputy operations manager. We also spoke with the lead investigating police officer and the local authority safeguarding team.

We looked in detail at two people's care records to see how risks were managed for them. In particular we looked at assessments around bedrails and pressure mats. We also looked at records of two people who were subject to an application to deprive them of their liberty under the Deprivations of Liberties Safeguards (DoLS). We looked at records of accidents/incidents which had happened to people at the home in the previous two months. We looked at environmental risk assessments and at relevant policies and procedures.

Good

Is the service safe?

Our findings

We undertook this inspection because we wanted to check risks to people were being managed safely following an incident at the service. The director and the deputy operations manager had been at the service since the incident to liaise with all involved. They were also supporting the manager and staff to continue with their roles to provide a service to the other people at the home.

The provider's environmental risk assessment was reviewed in June 2016. The director said they did not feel there had been a significant safety problem at the home before the incident. They were in the process of reviewing the risk assessment to see if improvements needed to be made. Arrangements had been made before the incident to review the environmental risk assessment. The manager and deputy operations manager were in the process of updating the environmental risk assessment at the time of the inspection. The manager recorded in a statutory notification submitted to CQC, "Ongoing safety - we have considered ongoing safety in light of this incident. We have made some changes to our environmental risk assessment …"

The management team had last reviewed their environmental risk assessment in June 2016. This had included the external environment. This was due for review in June 2017. This assessment had identified the outside area as a whole and the potential hazards and control measures were recorded to reduce the level of risk. The locations identified as a risk covered all external areas, front car park and garden, rear garden, pond and side paths and steps. There were not specific control measures in place for all individual external areas. Following the incident the risk assessment was being amended to include actions taken and record any control measures needed. After the inspection the provider sent us the new revised assessment which was more specific to individual areas of risk and set out actions taken.

The provider had a locked door policy at the service. This was because the majority of people living at The Firs had a level of dementia and memory problems and would not always recognise dangers. This meant that several exit doors had keypads which required codes to be input, which were changed regularly.

People could access the patio through the conservatory door. We were told people liked to have the conservatory doors open in the summer so they could use the garden. The manager said staff would always be present at these times. The conservatory door had an alarm which was linked to the call bell system. The provider had made changes to the system to ensure that if the door was opened staff would always be alerted.

The director said they had arranged that alarm checks be added to the weekly maintenance checks at all of their services. Following the inspection, the provider sent us new documentation of weekly door alarm tests which had been implemented. This was in addition to environmental checks which were regularly undertaken by a maintenance person employed by the provider. These checks included fire systems checks, thermostatic water valves, shower heads being cleaned and checked, carbon monoxide monitors, emergency lights and lifting equipment. The provider also had external companies who undertook checks on pest control, fire equipment and lifting equipment.

Changes had been made to the locks systems in use in people's bedrooms on the ground floor which had doors which opened onto the home's garden. This was so people could be assessed individually and allocated a key as appropriate for their safety.

The provider had decided to have window restrictors fitted to the ground floor windows. These had been ordered and would be fitted when they arrived. The director said "Putting the restrictors in place are belt and braces." Following the inspection the provider made us aware that restrictors had been fitted where required.

We were shown the outside areas of the home and told by the manager that the garden was secure. We saw there was a gate which was secure. However there were areas in the garden where people could leave if they chose. It was confirmed by the manager that this was being looked at as part of the new risk assessment. Following the inspection the provider sent us a reviewed 'General environmental risk assessment which confirmed "Detailed Garden risk assessment to be put into place by end of March 2017."

Risks to individuals were being managed. Personal risks to people had been assessed. These included risk assessment of falls, malnutrition, skin breakdown due to pressure and risk of neglect. Where people had bedrails there had been a risk assessment undertaken. Risk assessments had been linked to people's care plans to guide staff how to manage concerns. For example, monitoring someone's weight more regularly and increasing nutritional intake. Where people were not able to consent to the use of bedrails the manager said they were not used. They said where people who lacked capacity had been assessed as at risk of falling out of bed they had mattresses placed on the floor to limit the impact of any fall. Two people at the home were using pressure mats which were connected to the call bell system. This meant when they stood on these mats it would alert staff. Both of the people using these mats had capacity and records showed they had agreed to their use.

Accidents and incidents were safely managed. Staff had recorded incidents and accidents and the actions they had taken on the provider's computerised system. These included where people had been agitated and staff had needed to take action to calm the situation. There were no incidents of people putting themselves at significant risk by their actions. The manager was well informed about incidents and accidents at the home. They said they looked at each incident to see what action had been taken and if there were any patterns.