The Firs Care Home Limited

The Firs Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 3 March 2016.The service was registered to provide accommodation for up to 28 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection, 27 people were using the service.

There was a registered manager in post, who was also the provider. 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 last inspection in April 2014, we had no concerns identified about the service.

The provider and deputy manager were not clear on their understanding and responsibilities in complying with the requirements of the Mental Capacity Act 2005 (MCA). We observed some people lacked capacity in certain areas; appropriate assessments had not been completed to show how people were supported to make those decisions. We saw that authorisations to request a Deprivation of Liberty Safeguards (DoLS) had been completed as appropriate.

The provider determined the staffing levels on the number of people living in the home and the level of support they required. Staff had been trained to support people's needs and on-going training was offered as directed from audits or staff request. Staff had identified they required additional training in MCA and DoLS. People felt safe within the service and staff understood their role in ensuring people were protected from abuse or poor practice.

Staff knew people well, many of the staff had been working at the service for a long time so people received consistent care and support. People were responded to in a kind and friendly manner and respected for their decisions. Risk assessments were in place to ensure people's safety was maintained.

Medicines were managed safely and in accordance with good practice. People received food and drink that met their nutritional needs and had a choice of the foods they wished to eat. Staff had made referrals to healthcare professionals in a timely manner to maintain people's health and wellbeing.

Staff were caring in their approach and they created a warm homely environment which people told us they liked and enjoyed. People felt confident they could raise any concerns with the provider and manager. There were processes in place for people to express their views and opinions about the home.

The provider and deputy manager had systems in place to monitor the quality of the service. People and their relatives had provided feedback on the service to drive improvements and personalised support. The provider had a 'hands on' approach in quality assurance to ensure good practice was maintained. Staff felt supported and respected by the provider.

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?

Good

People were protected from avoidable harm and abuse. Staff understood how to recognise abuse and what actions to take. Risks were managed and staff knew how to work safely. There were sufficient numbers of suitable staff to keep people safe and meet their needs. Staff were recruited in a safe manner and there were appropriate checks in place. Medicines were managed safely to enable people to take the correct medicine at the right time.

Is the service effective?

Requires Improvement

People were not always supported to make decisions and where there was a lack of capacity staff had not followed the requirements under the Mental Capacity Act 2005. Where people had their liberty deprived, the appropriate authorisations had been applied for. Staff received on-going training to maintain their skill levels but had not always reflected their learning to support people.
People were supported to eat and drink enough and maintain a balanced diet. People were supported to maintain their health and have access to health care when needed.

Is the service caring?

Good

People received support from staff who were kind and understood their individual needs. People were treated with dignity and respect and were supported to express their views about their care. People were encouraged to be as independent as possible and were involved in decisions that were made. Where people required an advocate they had been supported to access this service.

Is the service responsive?

Good

Staff knew the people well and we saw that the care that people received was tailored to the individual. People were able to choose how to spend their time and what activities to be involved with. People knew how to raise concerns and complaints and the provider responded to any issues raised.

Is the service well-led?

Good

The service had effective systems in place to monitor and improve the quality of the care people received. People and their relatives had been encouraged to be involved in the service. Staff felt supported by the provider

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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. Our inspection was unannounced and team consisted of one inspector and an 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.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also spoke with the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us.

We spoke with 11 people who used the service and six relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas.

We also spoke with three care staff, the cook, the handyperson, the deputy manager and the registered manager. We spoke with one health care professional about the service. We reviewed three staff files to see how staff were recruited. We looked at the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. We reviewed four care records to see if the documented care reflected the same as the care being delivered. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "People know exactly what they are doing and they are regularly checking". One relative told us, "They felt their relative was safe and staff had responded to them to keep them safe. The staff had recently received training in safeguarding and knew what constituted abuse and what to do if they suspected someone was being abused. One staff member said, "I know about all the aspects of abuse. If I had any concerns I would go the senior or manager and feel confident they would respond." The registered manager kept a record of any safeguards. These included a comprehensive investigation and actions taken to reflect any ongoing learning. For example, a safeguard had raised a concern in relation to skin damage. Following the safeguard incident, all the people using the service were assessed by the healthcare professional service and equipment was provided to reduce any risk of future skin damage. We saw that staff ensured people used the equipment to support their safety.

Risks to people's safety were assessed and where risks were identified the care records we looked at had plans in place to guide staff on how to minimise the risks. For example, one person was struggling to mobilise and they required a piece of equipment. They had made a referral to an occupational therapist for further guidance to support the person and ensure their ongoing safety. The provider had completed a risk assessment to clarify the use of the equipment and guidance for staff.

We saw that the entrance to the service was safe. It was possible to enter the front garden from the car park but to exit, you required the key code. Within the home access to the first floor was via a door with a key pad entry and we saw back stairs used by the staff had a stairgate to restrict access. People and relatives understood the importance of the restrictions, which support people's safety. One relative told us, "They allow people's freedom and they manage the risk, compared with avoiding risk." In the relatives feedback survey one person had mentioned, 'I like the way people have access to the garden which is well maintained.' We saw that risk assessments had been completed to cover emergency evacuation, these plans provided clear information on the individuals needs to ensure staff would be able to support people's evacuation safety. This showed that the provider ensured people's safety around the service.

People told us there was enough staff to support them. One person told us, "They are very good the staff here." Relatives we spoke with had no concerns regarding the level of staff provided. One relative told us, "The staff are available; they are always busy." Staff we spoke with felt there was enough staff. One staff member said, "It's much better since we have had the kitchen assistant start." The provider told us that each week they met with the deputy to discuss the needs of the people using the service and the relationship to the level of staff. They told us they had increased the evening care staff to three when people's needs had increased. They told us, "It feels safer having the three staff at night."

All the staff had been employed for several years at the service. We saw that when new staff started working in the service, recruitment checks were in place to ensure they were suitable to work with people. This included a DBS check and references. A DBS provides a check relating to any previous criminal records. This demonstrated that the provider had safe recruitment practices in place.

The people we spoke with did not voice any concerns about their medicines and people told us they would get them in a timely manner. One person said, "I'm given my medicine on time every day." We observed people being given their medicines at lunchtime. We saw the staff member tell people about their tablets and what they were for. When the person had taken their medicine, the staff completed the medication administration record for each person. Staff who administered medicines were trained to do so and showed a good understanding about people's medicines. For example medicine which was prescribed to be given 30 minutes before the person had their food was given at the right time and the records were completed to confirm this.

We observed staff followed protocols for administering medicines prescribed on an 'as required' (PRN) basis to protect people from receiving too little, or too much medicine. The provider carried out medicines audits to ensure stock was maintained to meet people's needs. We saw and records confirm these were up to date and reflected any improvements.

Requires Improvement

Is the service effective?

Our findings

We saw that the provider and deputy manager were not clear on their understanding and responsibilities in complying with the requirements of the Mental Capacity Act 2005 (MCA).

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. We looked to see if the provider was working within the principles of MCA. Staff confirmed some people who used the service may lack the capacity to make certain decisions. The staff had not completed any mental capacity assessments and where people they had recognised may not capacity there was no information to confirm any decision had been made in the person's best interest. For example, one person had a pressure mat to alert staff if they moved out of bed so support could be given as they had been assessed as a having a high risk of falls. The staff told us the person was unable to give their consent to the mat and we did not see any best interest assessments to show why this mat was being used and whether this restricted them. Staff we spoke with did not demonstrate an understanding of the process to follow where people lacked capacity. We spoke with the provider and deputy about this who confirmed that, mental capacity assessments had not been completed. This meant that some people's rights under the MCA 2005 had not been addressed.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 11.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

The provider had made applications to the local authority in relation to DoLS. The provider had a system to monitor the DoLS applications. Where an application had been submitted this had been documented in their care records. The care records documented the application details and the support required to ensure the person is safe within the home until they receive the assessment outcome. Staff were able to tell us about how the DoLS legislation restricted people, but admitted they would like some additional training in this area. The provider acknowledged the need for all staff to receive up to date training to cover both MCA and DoLS and to enable them to complete the appropriate assessments to ensure people's safety and appropriate consent.

Staff told us they received a range of training. Some staff were unable to identify the recent training they had received and therefore the usefulness of the this. Other staff felt the training was regular and helped to develop their skills. For example one staff member told us they had received training in managing

behaviours. They told us, "It was good, it talked about distraction techniques." We saw that some people had behaviours that challenged and that the care records identified the guidance for staff in supporting them, using the distraction techniques method. We saw that a referral had been made to a health care professional for further advice. We discussed the training with the registered manager. They acknowledge that they had not checked staff competencies following their training and this was an area they would look to develop.

The registered manager told us their induction programme had a combination of shadowing an experienced member of staff and training. Established members of staff were able to tell us they had received this support when they had started. All new staff were to complete the care certificate within the initial 12 weeks of their employment. The provider confirmed that all new staff would be placed on this training. The care certificate which sets out common induction standards for social care staff and was introducing it for new employees. The Care Certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care.

People told us they enjoyed the food. One person said, "There is a good choice for breakfast and the 'dish of the day' was often the best of the day." A relative told us, "Food is very good, and there is a cooked breakfast available." The cook had a planned four week menu; people's choices had been considered as part of the planning of the meals. For example, people had asked to change the liver to a lasagne and the salmon to cod; the records showed these changes had been made. Any specialist diets had been considered and appropriate options provided.

People had been asked what they liked to eat and we saw preferences were noted in their care plans. We saw were people had requested a different choice this was provided. For example one person had asked for soup with bread. We saw they received this. We observed the lunchtime meal, people did not have to wait to be served and their choices considered. One person was reluctant to eat their meal. We saw the provider eat their own lunch with the people who used the service and tried to encourage the person to eat. After a short while an alternative to the hot meal was provided, which the person then ate. We saw that drinks and snacks were provided throughout the day. This showed the provider supported people to maintain their nutritional needs.

People were supported to maintain their health and wellbeing. We saw that referrals had been made to healthcare professionals when needed across a range of health needs. One health care professional we spoke with said, "The staff here are very supportive when needed., There is a regular group of staff who know people really well." They went on to say, "If the staff have any concerns they ask whilst we are here or contact us by phone."

Good

Is the service caring?

Our findings

People and their relatives told us they were treated with kindness and compassion. One person told us, "I just enjoy it here, there is lots of laughter." Another person said, "The staff are very kind and good, all of them, anything you ask, they do it". One relative told us, "Staff are all very kind, [the person who used the service] likes their company." We saw staff knew people well and were attentive to their needs. For example we saw the staff bring a hot drink for a person; the person asked if it contained their three and half sweeteners. The staff confirmed and the person said, "Just how I like it." We saw another person being offered their blanket.

Independence was encouraged and supported. For example one person enjoyed a visit to the shop daily. This person was unable to go out independently, we saw that the person was taken to the shop by staff and the details were documented in their care records. This ensured their safety without removing the person's independence.

People made decisions about their daily routine such as what time they got up and went to bed, and what they wanted to wear. One person told us, "I choose to rise early at 6am and I choose when I go to bed."

We saw were people did not have someone to support them, they had been referred to access an advocate. Records confirmed the advocates contact details and their role. We saw that an advocate visited weekly and build up the relationship with the person so they could provide the support they needed. An advocate represents the interests of people who may find it difficult to be heard or speak out for themselves.

People told us staff respected their privacy. One person told us, "Staff knocked on my door before entering." We observed when staff approached people to ask if they required support with personal care, they spoke quietly in their ear. Staff we spoke with gave several examples of how they ensured people's dignity. One staff member said, "We shut the curtains, ask politely, and wait outside the toilet if it is safe to leave the person." Another member of staff told us, "You need to ask permission and explain what you are doing."

Relationships that mattered to people were encouraged. We saw the staff greeted visitors and welcomed them, provided seating and refreshments to enable them to be with their relative. One relative told us when their relative had to consider fulltime care they wished the person to be 'cared for in a generous way' and this had been achieved at this service. They told us, "When you come through the door you feel warmth" Some other relatives had commented that they had not been charged when they had stayed for a meal with their relative including Christmas day.

Good

Is the service responsive?

Our findings

People told us staff knew how to support them. One person said, "When I came here, I had been asked at the outset of my needs and what happens here." They went on to say, "I don't have to wait, when I need help as I get it as needed." We heard free flowing conversations in relation to the local area, people's previous employment and aspects of their life. We saw people gained eye contact and lowered themselves to people's level when communicating. This showed us that the staff knew people and they were able to use this information to engage and support people's needs.

People were encourage to express their preferences and these were recorded in the care records. . For example we saw a reference to a person who liked wearing pyjamas, the person's chosen time they wished to get up or go to bed and one care record documented the person liked an extra blanket on top of their duvet. Staff we spoke to were able to provide the details of people's individual care. We saw the records had been reviewed monthly and any amendments made and information cascaded to staff in the daily handover. The handover provided the opportunity to pass on any changing information to ensure people received the appropriate care. For example, one person who used equipment to transfer from the chair on occasions was feeling unwell and required the support all the time. . We saw staff used the equipment and the care records reflected this. This showed people received the care they needed to support their changing needs.

There were activities to interest people within the home. Some were planned activities, which occurred on a regular basis. One relative told us, "Today is a singalong: at 2pm." We saw this took place led by a volunteer. People engaged in the activity and we saw people playing with tambourines. We saw staff encouraged people to join in. One person was singing so high, they started coughing. The staff immediately got them a drink and supported them until they stopped coughing. One relative told us, Their relative had come on 'leaps and bounds' since being at the service. People were able to use the services from the library, the church, and the local hearing and sight impaired club. One person told us, "I get a supply of books from the library once a month."

People and their relatives told us they felt able to raise any concerns and if they had a complaint, it had been dealt with. One person told us, "I feel content that if I complained something would be done." We saw the provider had a complaints procedure and that any complaints were recorded and responded to.

Good

Is the service well-led?

Our findings

There was an open and friendly atmosphere and people and their relatives told us they were happy living at the service. The provider who was also the registered manager, took an active role within the running of the service. We saw that they had a visible presence and had a good knowledge of the people.

Staff told us they felt supported by the provider. The staff team had all been at the service for many years, which they attributed to the support they received from the provider and the enjoyment they had from supporting people using the service. One staff member told us, "The manager is fair; you can approach her if you want to talk about anything." Staff told us they had regular supervision which they found useful. One staff member said, "The management listen to problems, they give good direction." Another staff member said, "The manager knows what's going on, which makes a big difference." Staff we spoke with all gave 'I enjoy the work' as the reason they were still working at the service. One staff member said, "We are a close knit working group." Staff were encouraged to share their views at team meetings. They had identified that a new washing machine was required; we saw this had been purchased. Both the cook and handyperson both commented on being able to obtain equipment or items to support their role. For example the handyperson had purchased the equipment to extend the ariel so the television could be placed on the wall.

The provider had completed a survey in relation to people and relatives feedback on the service. Relatives had identified an issue with lost laundry. The provider has now recruited a dedicated laundry person to support this aspect of the service. We saw the laundry staff sewing labels on garments. A staff member told me, "It's much better now we have the laundry staff, no lost laundry and its one less tasks for the care staff we can concentrate on the people." We saw that feedback on the actions taken in response to the survey was displayed on the notice board. People told us they had requested thicker chips and wholemeal bread, and the provider and cook confirmed these had been ordered.

The provider carried out audits such as checking the accuracy of care records to ensure the quality and safety of the service, and they made improvements where required. For example one person, following several falls had been referred to a health care professional for guidance and equipment. The equipment had been provided and the care records had been updated. We saw the provider completed audits and competency checks on the staff in relation to the administration of medicines. The audit showed all staff were competent, but some felt less confident. The provider had arranged for some additional training in medicines to support staff and increase their confidence.

The provider had fitted close circuit cameras in the communal spaces. This had been discussed with people and relatives and they understood what they would be used for. One person said, "It's for our own safety." Where people lacked capacity, the registered manager told us they would complete a best interest assessments or ensure people had the correct support through an advocate or relative. We saw the provider was obtaining everyone's consent before the cameras were to be used. The provider told us, it would be another way to check the quality of the care being provided and to drive any further improvements.

The registered manager understood the responsibilities of their registration with us. They had reported

significant information and events in accordance with the requirements of the registration. There had recently been a visit from the local authority who had made some recommendations for improvements. We saw these had been completed. This showed the registered manager listened and worked towards continued improvements.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care was not sought in line with legislation and guidance. This meant people could not be assured that decisions were being made in their best interest when they were unable to make decisions themselves.