Care Quality Commission

Firlawn Nursing Home Limited

Firlawn Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

We carried out this inspection over three days on the 2, 5 and 24 November 2015. The first day of the inspection was unannounced. There was a delay in the completion of the inspection, as the registered manager was on annual leave. Our last inspection to the service was on 31 October 2013. The inspection in October 2013 was made to check improvements had been made to keeping people safe. All shortfalls we previously identified had been addressed.

Firlawn Nursing Home provides nursing care to up to 40 people. The home consists of two buildings on one site, which are separated by a large garden.

There was a registered manager. They had been in post since 2013. 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

Summary of findings

meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present throughout the inspection.

People, their relatives and staff told us there were not always enough staff available. This was particularly apparent at times of staff 'calling in' sick at short notice and annual leave. Some comments indicated that call bells were not always answered in a timely manner and staff were not easy to find. People were largely unsupervised on one floor whilst staff assisted one person to have a bath.

Less visible areas of the home such as beading on over-bed tables and skirting boards were not clean. At various points in the home, paint work was chipped and difficult to wipe down. There were toiletries and nail files and clippers in the bathroom. These items presented infection control risks if used communally.

People's medicines were not safely managed. There had been a number of errors and staff had not consistently signed the records, to show they had given people their medicines, as prescribed. Records did not show people's topical creams had been consistently applied. Clear guidance was not available to inform staff about "as required" medicines.

Care plans were difficult to follow and did not clearly inform staff of people's needs and the support they required. The plans lacked detail and were not measureable. Staff had not consistently completed people's care charts. This did not enable effective monitoring of key areas such as nutrition and hydration, the management of continence and healthy skin. Following the inspection, the registered manager and the operations manager told us staff training in this area had been arranged.

People told us they felt safe. They were complimentary about the staff and the care they gave. Staff spoke to people in a friendly, respectful manner. They had a good rapport with people, which showed effective relationships had been built. Staff knew people well and encouraged decision making and independence. There was a strong focus on Firlawn Nursing Home being each person's home. There were many positive interactions between staff and people who used the service. This included staff assisting a person to eat and supporting people whilst unwell.

People knew how to make a complaint and were confident any issues would be appropriately addressed and resolved. People said they had enough to eat and drink. There were positive comments about the food. This included the way in which the food was cooked and presented and the choice available. People were offered a range of alternatives, if they did not like what was on the menu.

People received good support to meet their health care needs. A GP and nurse practitioners visited frequently to monitor people's health and to review treatment plans and medicines. Health professionals could be contacted at other times for advice or to visit, as required. Records showed contact had been made with specialised services such as the speech and language therapist.

Staff received a range of training to help them do their job effectively. The registered manager was passionate about training and said it ensured an effective team. They were looking at ways to develop training provision within the home. Staff received support on an informal basis and within structured meetings with their line manager. This enabled staff to discuss their role and any concerns they might have. The registered manager told us focus was to be given to staff appraisal as they were behind in this area.

People were supported by staff who had undertaken a thorough recruitment process. This ensured all staff were suitable to work with vulnerable people. Staff had received up to date safeguarding training and were clear of their responsibilities to recognise and address potential abuse.

The registered manager described themselves as a "people person" with an emphasis on consulting and enabling. There were many positive comments about the registered manager. They demonstrated a passion for their role and kept up to date with best practice from a variety of sources. A system was in place to monitor the safety and quality of the service provided. The registered manager analysed information such as accidents and incidents to identify possible trends. People were

Summary of findings

encouraged to give their views about the service. This was informally, at meetings or by using questionnaires. The feedback received was used to help improve service provision.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

This service was not always safe.

People, their relatives and staff told us there were not always enough staff available. This was particularly apparent at times of staff sickness or annual leave.

People did not always receive their medicines in a safe manner. Records did not show people had consistently been given their medicines, as prescribed.

Less visible areas of the home were not clean. Staff had received training but not all practices, promoted effective infection control.

People felt safe. Staff received safeguarding training and were aware of their responsibilities to recognise and report potential abuse.

Is the service effective?

Good

This service was effective.

People were supported by staff who felt well supported. Staff received a range of training to help them do their job effectively.

People received enough food and drink and were complimentary about the meals provided.

People received good support from local GP surgeries and other agencies, to meet their health care needs.

Is the service caring?

Good

This service was caring.

People were complimentary about the staff and their caring qualities. Staff spoke about person centred care and were knowledgeable about people's needs and preferences.

People were treated with dignity and respect.

Staff had a good rapport with people. There were many positive interactions between people and staff. People were offered choice, given reassurance and involved in interactions.

Is the service responsive?

Requires improvement

This service was not always responsive.

Care plans did not fully reflect people's needs and the support they required.

Not all staff had accurately completed people's care charts. This did not enable people's food and fluid intake, continence management or re-positioning to be effectively monitored.

Summary of findings

People and their relatives were happy with the care provided. They knew how to make a complaint and felt listened to. People were confident any issues would be properly resolved.

Is the service well-led?

Good 

This service was well-led.

The registered manager was passionate about their role and committed to ensuring people received a good standard of care.

The registered manager had a consultative management style and encouraged people to give their views. This feedback was used to develop and improve care provision.

There were a range of audits to assess and monitor the safety and quality of the service. This included an analysis of accidents and incidents to minimise further occurrences.

Firlawn Nursing 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 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.

This inspection was unannounced on 2 November and continued on 5 and 24 November 2015. The inspection was carried out by one inspector, a specialist advisor who was a registered nurse 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.

In order to gain people's views about the quality of the care and support being provided, we spoke with thirteen people, five relatives and four health/social care professionals. We spoke with eight staff, the registered manager and the operations director. We looked at people's care records and documentation in relation to the management of the agency. This included staff training and recruitment records and quality auditing processes.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We asked the provider to complete 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. The PIR was received on time and fully completed.

Requires improvement

Is the service safe?

Our findings

Before our inspection, we received two concerns about staff shortages and the impact this had on the quality of the service people received. We asked the registered manager to investigate the concerns and inform us of their findings. They did this and as a result of the investigation, the numbers of staff on duty during the day were increased by one. The registered manager told us they were pleased that staffing levels had increased, as they felt this was necessary. They said with the staffing increase, there were usually two registered nurses and six care staff on duty across the two units to support 40 people. This involved a registered nurse and two care staff in one building with 14 people. In the other building, there were four care staff and a registered nurse with 26 people. The staffing roster showed these numbers were generally adhered to although at times of staff sickness, there were sometimes five care staff and two registered nurses on duty.

Some people, their relatives and staff told us despite the increase of staff, there remained insufficient staff available. One person told us "it sometimes takes a long time to answer the bell". Two people who stayed in their rooms told us they had limited conversation with others and wished staff had more time to chat. Another relative told us call bells were sometimes slow to be answered. They continued to say "it's sometimes difficult to find staff. I do not feel there are enough staff for the needs of the residents". Another relative told us "it is busy and it depends who is on, when X gets his pad changed". One member of staff told us "I'm not going to lie to you but there are some days when it's really busy and people may not get their wash until later in the day and that's not right". Another member of staff told us "the care is good but it would be even better if we had more staff. Sometimes it can be a bit rushed and that's not fair on people". Another member of staff told us "attention to detail can be difficult at times due to the time available. Sometimes people's nails don't get cut, as often as they should. It's the little things but they're so important". Other staff told us the number of staff available impacted on maintaining care plans and completing care records in a timely manner.

Within one building over two floors, there were 18 people out of 24, who needed the assistance of two staff, to help with their personal care. Three of these people were receiving end of life care. Staff told us this level of dependency was time-consuming and impacted on others. During the inspection, one person was supported to have a bath. They were assisted by two staff for a period of 40 minutes. This meant that whilst the two staff were in the bathroom, there were no staff available to support or supervise other people. This presented a risk to people's safety. After the inspection, the registered manager and the operations manager told us other staff would have been available if required. One member of staff told us they felt the number of falls increased, when there were less staff on duty. The registered manager told us they would look at the staffing arrangements, as they wanted to minimise risk and ensure people did not feel rushed. The operations manager told us they believed the home was overstaffed as shown by the dependency tool used. They said they would review arrangements and provide additional staff if required, in line with budgetary restraints.

Whilst there were concerns about the numbers of staff available, some feedback indicated the staff were not always allocated efficiently. There were some comments that some staff took their breaks at inconvenient times or had additional cigarette breaks. This impacted on the numbers of staff available particularly at key times of the day. The registered manager told us they would monitor and address this accordingly.

Information sent to us before the inspection, indicated there had been seven medicine errors in the last twelve months. These had involved people not receiving their medicines as prescribed and errors with prescriptions. The registered manager had discussed the medicine errors with the local safeguarding team. They had reassessed the competence of those staff involved and had provided additional support and training in the safe administration of medicines. The registered manager told us they were concerned and frustrated that the errors kept occurring. The operations manager told us if errors continued after additional training and support had been given, staff would be officially reported to their regulatory body, the Nursing and Midwifery Council (NMC).

One person told us there had been a mix up with their medicines. They said a member of staff went to give them some medicines at tea time but they did not have any prescribed at this time. They said that due to this, they knew the medicines must have been for someone else. The

Is the service safe?

person was concerned others may not have been as aware and might have taken them, in error. Records showed this incident had been investigated and appropriate measures were in place to prevent a reoccurrence.

Not all staff had consistently signed the medicine administration record (MAR) when supporting people with their medicines. A checklist was in place to identify such shortfalls. However, the omissions, showed staff were not following the home's medicine policy. In addition, the records did not show people had been given their medicines, as prescribed. Information about the application of topical creams was not consistently detailed on the MAR or the separate 'cream' charts in the person's bedroom. Records did not show topical creams had been applied, as prescribed. There were no protocols in relation to medicines to be administered "as required". This did not enable staff to ensure the medicines were given as prescribed. Within one person's room, there were boxes of food supplements on the floor. This did not ensure safe storage.

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

The home was generally clean although those areas less visible were not. This included debris on the ridges of handrails and the beading on over-bed tables. There was some dust on skirting boards. Staff told us they had cleaning schedules although said it was sometimes difficult to ensure all jobs were done, especially at times of staff sickness. One member of staff commented they would like to undertake more deep-cleaning, as they could tell things were not being done as often as they would like. Another member of staff told us it was difficult, as the domestic staff generally finished their shift at 2pm. This meant some areas such as toilets, would not be cleaned until they arrived for duty the next day. Staff told us there were two domestic staff and a housekeeper available across both units. Staff explained this was insufficient, especially at times of staff sickness or annual leave. The registered manager told us they were trying to recruit bank staff but without success.

Whilst staff had received up to date training in infection control, there were shortfalls which did not promote good practice. Some of the paintwork around the home was chipped. This did not enable surfaces to be properly wiped down. The registered manager and the operations manager told us the home was a working environment and chips in paintwork were a result of moving equipment. They said a full refurbishment plan of the environment was in place.

There were toiletries, nail files and nail clippers in the bathroom. Using these items communally, increased the risk of infection. After the inspection, the registered manager and the operations director told us the items were not used communally but left in the bathroom accidently by staff. The light pull chords were discoloured and not all bins were foot operated. This increased the risk of cross contamination if people touched the lid with their hands, when discarding any waste. Within people's records, there was an assessment which detailed the individual's risk of infection. Whilst these had been completed, there were no plans in place to show staff how the risk should be managed. The registered manager told us they had identified the cleaning of the home in less visible areas needed improvement. They said they had started to address these areas with staff.

This was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. There was information about keeping people safe, available for staff reference. Staff told us they received safeguarding training and the registered manager ensured they had regular updates. Any incidents were appropriately referred to the safeguarding team for advice or investigation.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a 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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff had knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Various Deprivation of Liberty Safeguards applications had been appropriately sent to the appropriate local authority. Evidence of these, were located on people's files. There was a section in people's care plans about capacity, consent and decision making. The information was not always decision specific and did not show the processes used and those people consulted with. The registered manager told us they were working on this area with staff.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All except one staff member told us they felt well supported by each other and the registered manager. They said communication was good and they were fully informed of people's needs and the support they required. There was a brief meeting each morning, with the heads of department. This enabled information to be shared and any concerns to be raised. Staff told us they were provided with emotional support when dealing with difficult situations. This included discussions and reassurance when supporting people at the end of their life. In addition to day to day support, the majority of staff told us they received formal one to one supervision. This enabled staff to talk about their work, their own development and any areas they felt challenging. Some staff told us they had not received formal supervision. They did not know the reasons for this although one member of staff told us "supervision seems to be if you've done something wrong". The registered manager confirmed that any issues were addressed during a formal supervision session so this view was partly accurate. They said some registered nurses were better at facilitating supervision sessions than others. This meant the frequency of sessions sometimes varied. The registered manager told us they would address this.

Some staff told us they had not received an up to date appraisal. This was a formalised discussion about the staff member's strengths, achievements and any support they required to develop their role. The registered manager told us because of other commitments, they had started the process of appraisals but were behind in their completion. The registered manager told us they were aware of this shortfall and would continue addressing the list of those appraisals required.

Staff told us they received training to ensure they had the knowledge and skills to do their job effectively. All staff told us the training opportunities were good although there was no longer a training manager in post. Staff told us they had undertaken all mandatory training such as protecting people from harm, emergency first aid, moving people safely and infection control. They said in addition, they completed training in topics associated with older age or specific health care conditions. This included hydration and nutrition, pressure ulcer prevention, palliative care and Motor Neurone Disease. Some staff told us they had not undertaken any training in dementia care. The information the registered manager sent to us before the inspection, confirmed this. The registered manager told us they were committed to staff training as it was essential to ensure high performing staff. They said they wanted to improve the opportunities available to staff and would be looking into ways of achieving this.

All staff had individual training profiles showing the training they had undertaken. Whilst the registered manager was aware of any shortfalls, there was not an overview, such as a training matrix. This did not enable the completion of staff training to be seen "at a glance". The registered manager told us they would develop a format for this purpose.

Staff told us the training was delivered in different ways which made it varied and interesting. They said some training was undertaken 'on line', by completing work books and by external speakers. One health/social care professional told us they had facilitated staff training, which had been well received. They confirmed staff were eager to learn and showed a commitment to the people they

supported. Another health/social care professional told us staff readily followed instruction and always gained advice if they were not sure. Staff told us there were two staff who were manual handling trainers. This enabled staff to receive training whilst working with people and to gain specific advice about any challenges. A manual handling trainer confirmed they were able to target the training to people's needs and could identify any poor practice whilst working with staff.

People told us they liked the food. There were various comments such as "it's varied", "it's home cooked", "we get a choice", "you can have what you want to eat, up to a point" and "it's always good, they will give you something else if you do not like what is on the menu". One person told us a vegetarian option was available such as vegetable cottage pie, cauliflower cheese and vegetable stew. Another person told us they had a restrictive diet due to a health care condition but this was well catered for. Staff told us they often ate at the home and confirmed the food was good. One member of staff told us "the food is lush. That's something we're really good at here. People get good food". Another member of staff told us "it's all cooked from scratch. Good home cooking and traditional foods". People had a choice of two dishes at each meal time and there were alternatives if these foods were not liked. People chose their meals the day before from a verbal description. On the first day of our inspection, the lunch time meal was beef stew or mushroom risotto served with cauliflower and diced swede. There was pineapple sponge pudding and custard or ice-cream for dessert. Staff told us people could have the alternative if they had changed their mind or had forgotten what they had ordered. They said many people had small appetites. In order for the food portions not to be overwhelming, meals were served on smaller plates. One member of staff told us people's appetites had improved, as a result.

People had been assessed in relation to their risk of malnutrition. However, the assessments were not easy to follow and did not detail how the outcome of risk was reached. Staff were aware of those people who were at risk of malnutrition and those who needed additional support. They told us some people had fortified foods, supplement drinks and additional snacks between meals. One member of staff told us "people can have whatever they want. We try to encourage people to eat what they can, when they want it". Another member of staff told us a person was losing weight due to their health care condition. They told us "we try everything. They can have what they want". However, these views were not reflected in people's records. According to two people's food charts, they ate very little in a day. Staff had not recorded alternatives that had been offered or regular snacks between meals. One record stated the person had refused the soup, as they did not like it. There was no information to indicate the person was offered an alternative. The medicine administration records showed people had been prescribed food supplements but these had not been consistently recorded, as given. Staff told us they were able to contact dieticians and speech and language therapists if they were worried about a person's nutrition.

There were clear systems in place to meet people's health care needs. One GP told us they visited the home on a weekly basis. They said this was to monitor people's ongoing health care needs and to review treatment plans and medicines. They said the weekly visits were formalised to ensure effectiveness but staff were also able to gain advice or raise any concerns they had about people's health. A nurse practitioner and a Motor Neurone Specialist Nurse told us they also visited the home on a regular basis. They said staff called them for advice when appropriate and followed instruction well. The health/social care professionals told us the registered manager and staff were clearly aware of people's needs and provided a good standard of care.

Records showed people had access to a range of health care services. This included chiropody, speech and language therapy and attendance at hospital appointments. On the day of our inspection, one person was visiting the dentist. Staff told us they received good support from local health care professionals. This included working closely with the local hospice to gain advice and support for people nearing the end of their lives.

Good

Is the service caring?

Our findings

People told us they liked the staff. They described staff as "caring", "respectful" and "patient". One person was complimentary about the staff but found agency staff not as good. This was because they were not so aware of their needs. After the inspection, the provider told us the agency had been spoken to about the quality of some of their staff. A relative told us the care they observed was "kind and with respect and dignity". The relative told us they were always treated well when they visited. Another relative told us "it's a nice care home. Staff are patient and kind even with people that are more challenging". One member of staff told us "the best thing about this place is the staff. They all care about the residents and do what they can for them. It's a supportive environment". A health/social care professional told us "the staff are very caring. They're concerned about people".

There were many positive interactions between people who used the service and staff. One member of staff assisted a person to eat. They spoke to the person in a soft voice, leant towards them and stroked their arm. They were attentive and asked the person how they were feeling and if they were comfortable. The member of staff gave encouragement and asked the person what they wanted to eat. They explained the food "looked good" but said the person could have an alternative if they wanted one. The member of staff used a teaspoon when assisting the person to eat. They placed small amounts of food on the spoon and gave the person time. Another person told staff they wanted a cup of tea. The member of staff responded by saying "of course. Come with me and we'll go and get one". They gestured to the person and offered their hand. The person smiled and responded by accompanying the member of staff. They talked to each other as they walked along the corridor. Another person was concerned as the bottom sheet of their bed had been changed and they could not remember why. They apologised for being "a nuisance". A member of staff gave reassurance in a sensitive manner. They quietly explained about the bedding and said "you're not a nuisance, that's what we're here for. If you're concerned, just ask, it's not a problem". Another member of staff noted a person had a runny nose. They asked the person how they were feeling and offered them a tissue. They then said "do you mind if I help you? There, that's better, that must have been very uncomfortable".

Staff knew people well and had a good rapport with people. They were confident when talking about people's rights to privacy, dignity, choice and independence. They said people were encouraged to follow their own routines. This included what time they got up and went to bed, as well as what they wore and how they occupied their time. Staff told us they always ensured personal care was undertaken in private with doors closed and curtains drawn. They said they promoted people's privacy when using the bathroom. This included making sure people were covered and undertaking care in a discreet and sympathetic manner. One member of staff told us they always made sure the person had their call bell and they waited outside the bathroom, until the person had finished. They said they were conscious of the person's feelings and insecurities. Another member of staff told us "I always think of the person as my mum and treat them in that way". There were further comments such as "we treat people as individuals", "I treat people how I like to be treated" and "it's important to see people as they were with a wealth of experience not just an older person sitting in a chair". The member of staff continued to tell us "we have a lot to learn from these people. They've lived through war, have travelled the world. We need to respect that". Another member of staff told us they were privileged to work with older people, especially at the end of their life. They were passionate about ensuring end of care was undertaken well. Staff told us they addressed people according to personal preference. One member of staff told us a person liked to be called a nickname which started in their childhood.

There was a member of staff who was responsible for organising social activities in the week and another at weekends. One member of staff told us the activity programme was arranged according to people's preferences but could be changed on the day, if required. The activities organiser told us they generally facilitated group activities. They said they visited those people who chose to stay in their rooms. However, these people's leisure time was the responsibility of the care staff. Specific events such as Halloween and Bonfire night were celebrated. One member of staff told us fireworks had been arranged with a hot dog supper. There were positive comments about some activities such as the knitting group. However, on the first day of our inspection, an exercise group took place. Not all people involved were fully engaged in the activity.

Good

Is the service caring?

There were records which showed the activities people had participated in. These had not been fully completed. One record stated the person was not able to undertake any activity but liked their radio on. This was not evident during the inspection and not shown on the person's records. Another person's activity record had been inconsistently completed. There were only three days in the month where an activity with the person had been completed.

Requires improvement

Is the service responsive?

Our findings

Not all care plans were up to date and reflected people's care needs. The plans lacked detail and were difficult to follow. The format meant current information was often lost in other, more out of date documentation. Phrases such as "needs assistance with their personal care" were used. This did not give staff sufficient guidance about what support people required. One care plan stated staff were to help the person achieve their expected standard and to be happy. The information did not detail how this was to be achieved. Another record stated the person was "mostly continent" but needed "more input with toilet needs". It was not clear what this information meant in practice. Another care plan stated the person required thickened fluids. There were no details to clarify the required consistency of these.

Skin integrity care plans did not state the measures in place to minimise people's risk of pressure ulceration. The information did not consistently state the specialist equipment in place or if the person needed support to change their position. When the information was stated, it was not measurable. For example, one care plan stated the person needed to be repositioned "regularly". The care plan did not state if this was on a two, three or four hourly basis. This lack of clarity increased the risk of the pressure damage. Some people had charts in their bedrooms, which showed the support they had received to change their position. Some entries stated "checked" or "repositioned". This did not give clear detail so that staff knew when and what intervention was required next. Some records indicated people had not been repositioned for five or six hour frequencies. This increased the risk of pressure ulceration.

One person had experienced sore skin due to their incontinence. A catheter had been inserted to minimise further risk. However, this had caused additional difficulties and the catheter was removed. There was not a care plan in place to minimise the risk of further soreness. Within the multi-disciplinary section of the care plan, it was stated a topical cream was to be prescribed to treat sore skin. Details of the soreness were identified in the person's daily notes but a treatment plan was not in place. The medication administration record showed the person's prescribed topical creams had not been consistently applied. Another record showed the person's heels were vulnerable to pressure damage. There was no care plan to inform staff how to minimise the deterioration of these areas.

Clear information was not documented in relation to the management of people's continence. Within one person's daily records, staff had recorded that the person was constipated and required suppositories. The elimination care plan did not detail the management of the person's constipation. The medicine administration records showed the person had been prescribed laxatives but these were often refused. It was not clear how staff were required to manage the person's refusals. Another person's records stated their bowel movements were to be monitored. Their care chart did not consistently show this information. Records did not consistently state people's incontinence aids were frequently changed.

The charts used to monitor people's fluid intake were not consistently completed. At 10.35 on the first day of our inspection, two records showed people had not been supported to have any food or drink since the following evening. The daily amount of fluid taken had not been totalled at the end of each day. This did not show people's fluid intake was being consistently monitored and increased as appropriate. One member of staff and a health/social care professional told us they believed this was a recording shortfall, not a practice issue.

Within people's records in their bedrooms, there was a document detailed "A bit about myself". This information had not been consistently completed.

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

People looked well supported and were complimentary about their care. One person told us "they get the hoist right and position my pad correctly". Another person said "they will do anything you ask. They are very obliging". A health/social care specialist told us "I take my hat off to them. They go beyond the call of duty. I think they did do a fantastic job. They do exactly what I ask. They observe, monitor and keep me informed. They're great."

Staff were responsive to people's needs. During the first day of our inspection, one person was not well. They were sitting at the dining room table but could not be roused by staff. A member of staff immediately called the emergency bell to gain the assistance of other staff. Staff responded

Requires improvement

Is the service responsive?

quickly and called the emergency services. They placed the person in the recovery position whilst giving constant reassurance. They gave the paramedics a clear, concise handover of the person's condition and supported the person attentively. Staff informed the person what was happening and were encouraging when the person began to respond.

Staff noted that one person's health was deteriorating. They were receiving end of life care and there was concern that the person was not entirely comfortable and was possibly in pain. Discussion was held with the GP and local hospice and as a result, a syringe driver was set up. This is a device which provides sedation and pain relief at the end of a person's life. Staff were sensitive and concerned about the person's wellbeing. Ancillary staff told us they were not permitted to undertake any care provision but would inform the nursing staff if a person was agitated or in pain. They said the staff team worked well together to ensure people received the best care possible. One member of staff told us "we always work around a person and are sensitive to their needs. If it's not appropriate to clean a person's room fully, we quietly do what's essential to make the area tidy. The rest can be done another day".

Another member of staff communicated with a person effectively using technology. They spent time with the person and ensured they understood what the person wanted. Staff assisted another person with their mobility using a hoist. They explained each part of the process and gave reassurance throughout.

People and their relatives told us they would tell a member of staff or the registered manager if they were not happy with the service they received. People told us they felt listened to and were confident any issues would be resolved quickly and effectively. One relative however, did not want to go into too much detail about complaints, as they were worried about how this might affect their family member's care. The registered manager was disappointed with this view. They said they wanted people and their relatives to openly share their views without fear of reprisal. They told us they believed raising concerns was an essential way of improving the service. The registered manager told us they encouraged people, relatives and staff to raise any concern however small. All issues raised were recorded as a complaint. Records showed all issues were appropriately investigated and actions taken to minimise further occurrences.

Good

Is the service well-led?

Our findings

The registered manager started employment at the home in 2013. They were passionate about their work and had strong beliefs about people's rights and ensuring a person-centred service. The registered manager told us they were a "people person". They described their management style as "consultative" "enabling and empowering" and "listening, sharing ideas and trying things out". They said they enjoyed talking to people, relatives and staff and would cover shifts if there were staffing shortages. The registered manager told us they had an excellent team of staff who worked hard to implement the ethos of the home. The registered manager told us they kept up to date with best practice by reading various journals, researching topics on the Internet, attending meetings with other managers and completing training courses.

There were many positive comments about the registered manager, their attitude and practice. One member of staff told us "the manager is so compassionate. She wants the best for the residents and the staff and promotes this, at all times". Another member of staff told us "she is excellent, fantastic. She goes far beyond her call of duty. She is a great asset here". Another member of staff told us "the manager is very special. It's a special place. All the residents know her and she knows exactly what's going on. She's the best manager I've ever had". Another member of staff told us "the manager is very caring, very proactive, she's great. She suggests things and has a 'go for it' attitude".

Whilst there were many positive comments about the registered manager, staff and health/social professionals raised some concern about recent conflict within the management team. They said one senior staff member had left, which had impacted on the dynamics of the team. In addition, a new operations manager had been deployed to assist with the management of the home. This had instigated some changes and differences in management styles. From various discussions, it was apparent that these factors had impacted on staff morale. There were many comments, which indicated the registered manager was not being well supported. The registered manager confirmed the transition had not been easy and whilst they did not want to appear negative, at times they felt individual roles were not clear. The registered manager told us whilst they did not receive formal supervision to discuss particular issues, they did frequently meet with senior managers.

The operations manager told us their post had been devised to assist the management of the home. They said they were looking for the home to be efficiently run in a cost effective way. The operations manager told us various systems had been implemented and a refurbishment programme had been devised. This included replacement of worn and stained carpets, the replacement of old furniture and refurbishment of the bathrooms. There were positive comments about the refurbishment although one staff told us they did not want the new furnishings to take away the homely nature of the service.

Whilst identifying the registered manager undertook their role well, some staff commented they would appreciate more leadership from the registered nurses in charge of the shift. One member of staff told us in their previous role, the registered nurses would check care charts at the end of the day to ensure they had been completed appropriately. They said this did not happen at Firlawn Nursing Home. Another member of staff told us they would like the registered nurses to show their supervisory role and ensure all staff worked efficiently, to their full potential. The registered manager told us they would address this with the registered nurses.

There were many positive comments about the home. These included "it's really homely and doesn't have long corridors, which is more like a home", "it's got a lovely, comfortable feel" and "it may not be smart in décor but the care makes up for it". One health/social care professional told us "the home is a bit scruffy around the edges and it could do with a tidy up but the care is good." A relative told us "the home does look tired and it could do with a lick of paint".

There was a programme of audits to assess and monitor the quality of the service provided. These were undertaken at varying frequencies and covered topics such as infection control, medicines and care planning. The registered manager looked at incidents and accidents to see if there were any trends. Action had been taken where required. There was an analysis of those people at risk of malnutrition or with wounds.

Good

Is the service well-led?

Records showed the servicing of equipment to ensure all items were safe to use. Hot water temperatures were monitored and checks were undertaken to minimise the risk of legionella. During the inspection, there was a fire drill to ensure staff were familiar with the fire safety procedures.

There were questionnaires on the notice board in the entrance area of both units. People or their visitors were able to help themselves to the questionnaires in order to give their views about the service, when required. The registered manager told us the questionnaires were sent to people to complete, on a yearly basis. The feedback was then coordinated and action plans devised. People, their relatives and staff told us the registered manager held various meetings to enable feedback to be gained about the service. They said the registered manager listened and acted on issues if at all possible. One relative told us how the registered manager had looked into getting their family member a new wheelchair. They said it had been a "godsend" as the person was able to go out for longer periods due to being comfortable in their chair.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not given their medicines in a safe manner and errors had occurred. Staff had not consistently signed the medicine administration record to show that medicines or topical creams had been given as prescribed. Protocols were not in place in relation to "as required medicines". Regulation 12(1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Less visible areas of the home were not clean and there were shortfalls in practice which did not promote good infection control principles. Regulation 12(1)(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care plans did not clearly identify people's needs, their preferences and the support they required. Care charts did not monitor aspects of a person's care such as hydration, continence and the management of healthy skin. Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's care records did not evidence that best interest decisions were carried out in line with the Mental Capacity Act 2005, Code of Practice. Regulation 11(3).