Firgrove Care Home Limited

Firgrove Nursing Home

Inspection report

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11 September 2018
13 December 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Firgrove Nursing Home provides accommodation, care and support for up to 35 people. The service provides support to older people, those living with dementia or mental health conditions, or people with long term health needs such as Parkinson's Disease. At the time of our inspection 18 people were living at the home.

Firgrove 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. Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Firgrove Nursing Home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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. At the time of our inspection the registered manager was also the nominated individual for the service.

We undertook a comprehensive inspection took place on 10 and 11 September 2018 which was unannounced. Following that inspection, we received information of concern in relation to staff recruitment. We undertook a further visit to look into those concerns on 13 December 2018. We announced this visit and we looked at the key questions of Safe and Well Led. This report covers our findings at both visits.

This is the first time Firgrove Nursing Home had been rated Inadequate and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following the last comprehensive inspection of the service in September 2017, the overall rating for the service was Requires Improvement with three breaches of regulation. People's social needs were not being met and people were at risk of social isolation; consent to care and treatment was not always sought and documented in line with legislation; and there was a failure in some systems for monitoring standards and quality. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions to at least Good. At this inspection, although some improvements had been made, there remained areas of significant concern. We did not find these inconsistencies had impacted on the safety of people, but these demonstrated shortfalls in quality monitoring and management oversight of some aspects of the service.

Quality monitoring systems were not effective in identifying shortfalls and driving improvement and the registered manager lacked oversight of these processes. Management oversight of recruitment processes was not effective. There was no robust system in place to ensure that required recruitment checks on staff were always made to ensure staff were suitably skilled and qualified to carry out their roles. There was not always sufficient staff deployed in a way to support all people's needs. Staff training was not always delivered by someone with the appropriate qualifications and competency to do so. Records in relation to maintenance of the building were not well organised to support the registered managers oversight of safety. Care plans lacked information to identify people's preferences and support their other needs such as access to activities. People had access to some activities, but these were limited and not always person-centred.

People told us they felt safe. One person told us, "I feel safe here, I have no concerns." Risks to people had been identified and staff understood people well and how to manage risks to help ensure people were safe. People were supported to receive their medicines safely by staff that were trained in administering medicines.

People were protected from avoidable harm. There was a safeguarding policy and staff received training. Staff knew how to recognise the potential signs of abuse and knew what action to take to keep people safe.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff understood best interest decision making where people lacked capacity in line with the principles of the Mental Capacity Act 2005. Staff sought people's consent before giving personal or nursing care.

People were supported to maintain their health and had assistance to access health care services when they needed to. Staff supported people by arranging healthcare appointments for them. We saw people had access to services such as tissue viability nursing, a GP and chiropody within the home.

People told us the staff were kind and caring and they were happy with the service they received. We saw positive interactions between people and the staff caring for them. Staff said they enjoyed working at the home and felt supported by the registered manager and deputy manager.

Concerns and complaints were responded to and the provider displayed the complaints policy within the home.

We found 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. We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The provider did not always ensure appropriate checks were carried out to ensure staff were suitably skilled and qualified to carry out their duties.

The provider did not always deploy staff in a way that met all people's needs.

Risks of the environment were assessed but safety checks were not always up to date

Risks to people were assessed and well documented, so staff knew how to keep people safe.

The provider had policies and procedures on safeguarding people from possible abuse and neglect. Staff knew how to recognise the signs and they knew what to do if they suspected any abuse had occurred.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always ensure staff had the skills, knowledge and experience to deliver effective care. Training was not always delivered by someone with the appropriate qualifications and competency to do so.

Consent to care and treatment was sought by staff on a daily basis, and staff understood their responsibilities with regard to the Mental Capacity Act 2005.

People were supported to eat and drink and maintained a balanced diet.

People had confidence in the skills of staff.

People were supported access other health care services.

Is the service caring?

Good

The service was caring.

People told us they felt well cared for by staff who respected their privacy and dignity.

People were encouraged to maintain contact with their family and friends and we saw people visiting throughout the inspection.

Records were kept securely and people's information remained confidential.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements had been made to ensure people had access to activities but this needed time to be embedded.

Records were detailed and care was person-centred with respect to healthcare needs but lacked information about people's personal history and preferences.

People knew how to complain and felt comfortable to do so and said their concerns were addressed.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Systems and processes for monitoring the quality of the service were not always effective in identifying shortfalls and inconsistencies.

Records were not always organised to support management oversight.

There was a clear management structure, staff communicated well and felt supported.

Firgrove 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 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.

A comprehensive inspection took place on 10 and 11 September 2018 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has a personal experience of using or caring for someone who uses this type of care services. Following some information of concern, a further site visit took place on 13 December 2018 and was announced. The inspection team consisted of two inspectors and an inspection manager.

Before the inspection we reviewed information we held about the service including any notifications complaints or safeguarding alerts that we had received. A notification is information about important events which the service is required to send to us by law. We contacted the local authority and people who commissioned services from the provider to obtain their views. Due to a CQC technical error, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually 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.

During the inspections we spoke to the registered manager, deputy manager, a director and a range of other staff including four carers, the cook and the cleaner. We spoke to the activities co-ordinator who started working at the service on the first day of our inspection. We spoke to eight people who used the service and three of their relatives. We spoke to two health and social care professionals who were visiting the service at the time of our inspection. We looked at all areas of the building including the kitchen, laundry, people's bedrooms and bathrooms and the communal areas such as the lounge and dining room.

We looked at a range of documents including policies and procedures such as safeguarding, incident and accident records, medication protocols and quality assurance information. We looked at care plans for four people who used the service. We reviewed team meeting minutes, observed staff handover and reviewed

four staff files including information about recruitment and training.

Inadequate

Is the service safe?

Our findings

The registered manager had not implemented safe recruitment processes and not all appropriate checks were completed to ensure staff were suitable to work with the people. Not all staff had appropriate clinical registrations in place. This meant that not all staff who were employed as nurses were currently registered with the appropriate professional bodies. This has placed people at potential risk of harm for a significant period of time as people had been in receipt of clinical support and guidance from people not registered to provide such support. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. While all staff had a DBS on file, not all were applicable for working at Firgrove Nursing Home. Staff files included application forms and appropriate references. Records confirmed staff member's identities.

The registered manager had not ensured all staff were registered with the relevant professional body to ensure fit and proper persons were employed in order to keep people safe. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of these concerns, both relevant professional bodies and local authority safeguarding teams were notified. We also asked the provider to take immediate steps to ensure people's safety.

The registered manager had not deployed sufficient staff in a way that met people's needs. One person told us "The staff are very good, but we don't see them very often." Another person told us if they had a concern "I would ride it out because there is nobody to tell here." Another person told us that call bells were sometimes not answered quickly, particularly around mealtimes when staff were busy supporting people who needed assistance with eating. The person told us that sometimes they had to wait for an hour for assistance to get back to their room after supper and sitting in a wheelchair for a long period caused them "considerable leg pain." Another person told us "The staff are good but could do with more."

Staff gave mixed feedback about staffing levels. One staff member told us, "I feel they have enough staff" while another said, "We could always do with more staff." Other staff felt they did not always have time to give people enough attention and the mornings were busy.

Deployment of staff did not always support people's preferences, for example giving people choice of when to get up in the morning. Staff told us that the shifts were arranged so that night staff assisted people to get up between 7am and 8am. One staff member said, "Night shift get some residents up in the morning so the AM shift can support them." The night shift provided personal care to some people and helped others to eat. One person told us the one thing they did not like about living at Firgrove Nursing Home was that they had to get up and be sat in their chair in their bedroom ready for the medicine round at 7am though this was not their preference. The person said they had been told this was for safety reasons and to reduce the risk of choking. In the care plans we reviewed, we did not see this practice reflected in people's risk assessments for medicines.

While staff were attentive, they were very busy and people were sometimes left for long periods in one

location. For example, one person required a hoist to be transferred in and out of their chair. This meant they were unable to move independently and relied on staff for assistance. We observed this person was transferred to an armchair in the lounge area at 10am, ate their lunch in the armchair and remained seated there until 3.30pm. Over that period, our Expert by Experience was speaking to people in the lounge area and observed that the person received very little attention or stimulus from staff during this period.

At lunchtime we observed eight people who needed support with eating, and this required the support of all three care staff on duty, the registered manager, the registered nurse and the activities co-ordinator who had only started working in the service the first day of the inspection. This meant that two people had to wait to eat their meals until other people had finished, without ensuring their food was kept hot.

We discussed this with the registered manager and asked how staff deployment was arranged based on the needs of people. There was no specific system to determine how many staff were needed to support people living at Firgrove Nursing Home and ensure meet their needs. A management audit of 18 August 2018 documented that staffing levels were "maintained and planned well", but there was no detail of how this was determined. The registered manager told us that staffing levels were decided on a 'trial and experience' basis. If someone was very unwell or needed constant supervision, staffing levels may be changed but generally there was no detailed assessment of staffing based on the individual needs of people.

The registered manager had not taken a systematic approach to deploying sufficient staff in order to ensure the wellbeing of people using the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with the safety and maintenance of equipment and the premises were assessed. The fire alarm system and fire equipment were maintained and equipment, such as hoists, were regularly checked and serviced. Some safety checks were not up to date, such as gas safety which was overdue and this was resolved during the inspection. We highlighted to the registered manager that management oversight of risks associated with the safety and maintenance of the environment was an area that required improvement.

People had confidence in the staff caring for them and they told us they felt safe. A relative told us "My wife is very well looked after." One person told us, "I feel very safe here, I have no concerns." Risks to people's safety were assessed and detailed care plans were in place to guide staff on how to mitigate risks and provide care safely. The provider used a range of tools to assess specific risks to people, for example, a mobility care plan and falls risk. A Malnutrition Universal Screening Tool (MUST) was used to assess nutritional risks. Other tools were used to assess risks of pressure damage. For example, one person used a specialist wheelchair to support them. The person was at high risk of pressure damage. The person had a detailed care plan around this risk with guidance to staff on how to maintain the person's skin integrity. The person had a specialist pressure relieving hoist sling to specifically suit their needs. Where the person needed specialist support from a tissue viability nurse this was managed in a timely way and detailed records were maintained of specialist guidance for staff.

People received their medicines safely by staff who were trained and competent to do so. There were policies and procedures to support the safe administration and management of medicines. No one currently living at Firgrove Nursing Home managed their own medicines, but people were supported to take their medicines when handed to them if they were physically able to. Staff gave people their medicines, ensuring that these were taken before completing the medication administration record.

Medicines were ordered monthly and there was a procedure in place to manage any discrepancies in

delivery and obtain further medicines. Medicines were managed appropriately by the registered nurses and stored safely. People confirmed they received their medicines on time. Care plans contained detailed medicine risk assessments. Staff had regular knowledge checks and had access to the provider's own medication policy as well as to the British National Formulary. This is a reference book that contains a wide spectrum of information and advice on prescribing and pharmacology. Information about possible side effects were also held on people's individual files on the electronic care plan system.

People were protected by the prevention and control of infection. There was a detailed cleaning schedule and this included regular routines for cleaning of the premises and kitchen, as well as equipment such as mattresses, hoists, wheelchairs and commodes. One the day of inspection, we saw the cleaner was present and we found the home was clean. People told us staff followed good infection control routines and we observed this in practice. One person told us "I see them wash their hands and they use gloves."

People were protected against the risks of potential abuse. Staff understood safeguarding adults' procedures and what to do if they suspected any type of abuse. Staff members told us they would not hesitate to report any bad practice they witnessed or suspected, and they would report it to a manager straight away. One staff member said, "I would tell the nurse in charge if something's not right" and described how they would report the matter to the registered manager. A safeguarding policy and whistleblowing policy were available to staff. Staff had received safeguarding training and referrals had been made appropriately.

Lessons were learnt from accidents and incidents. There was a system in place to record accidents and incidents with information about what had happened, and any action taken to prevent a further accident as far as possible. For example, one person was at high risk of skin pressure damage and had developed a pressure sore. A detailed review of risks to the person was in the care plan, together with a detailed action plan to support the person. The registered manager worked in partnership with other health professionals including tissue viability nurses, the GP and a physiotherapist to consider any equipment that may prevent reoccurrence. Feedback for staff was given at regular handover meetings lead by either the registered manager or deputy manager.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2017 we found the care was not always effective. We rated this key question as Requires Improvement as the provider was not always ensuring care was being delivered in line with the Mental Capacity Act 2005 and this was a breach of Regulation 11 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider developed an action plan to address these issues and at this inspection we found that improvements had been made and the breach of regulation had been met. However, we found other areas of concern and this key question continues to be rated as Requires Improvement.

Management oversight of training was not robust. The registered manager had not ensured that training reflected current best practice and was being delivered by someone with the appropriate qualifications to do so. Staff had access to training in a range of subjects and much of the training was being provided in-house. Training offered to staff included specialist training such as speech and language therapy [known as SALT]. This is commonly used to help people with language or communication difficulties, as well as used to help individuals with difficulty swallowing and have risks associated with eating or drinking. According to training records SALT training had been delivered on 31 July 2018. Staff told us that in-house training had become more common in recent years. One member of staff told us "I would like further training on how to deal with more specific health conditions. It would be nice to do more training in that, rather than generalised training." The provider had a training calendar outlining the courses planned for the year, and this included a range of training covering health and safety topics as well as training to support specific aspects of nursing care delivery such as diabetes, dementia awareness and pressure ulcer awareness. The training was being delivered by someone without the relevant clinical competency, as the staff member was not registered with the appropriate professional body. After the inspection the provider showed us an action plan with details of how they planned to address this, including accessing training from external resources.

The registered manager had not ensured training was delivered by staff with the appropriate competency to do so and therefore could not be assured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular supervisions which they found useful and the registered manager confirmed this. Staff told us the registered manager supported them with identifying any areas for improvement. One member of staff told us, "Supervision is good for us." Another member of staff told us, "Yes, we have regular supervisions and they are useful."
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Under the MCA, people can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within

the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Since the last inspection improvements to care plans had been made and these were detailed and showed that initial assessments prior to people receiving care included whether people could make specific decisions for themselves. Consideration was given to whether people were supported by others to make decisions, such as an advocate or a person with legal authority to do so. Where people had someone with legal authority to support them this was clearly documented in the care plan. Where best interest decisions were made for people who lacked capacity, this was documented and we saw people were consulted appropriately.

The provider ensured that where people were considered for DoLS authorisation appropriate assessments were made and records were kept. The provider kept records for every person where a DoLS application had been made and was pending authorisation. At the time of our inspection, several people had DoLS authorisation pending and only one person had an authorised DoLS in place for use of bed rails in order to keep them safe. The provider had undertaken a specific risk assessment for this prior to applying for DoLS, and staff were aware the DoLS had been authorised for this person.

After the last inspection, the registered manager had arranged additional training for staff in MCA. Staff recognised that when people lacked the capacity to make some decisions, staff must act in their best interests and the person should be supported to make decisions where they can. One member of staff told us "Some of our residents can't make decisions for themselves" and demonstrated an understanding of best interest decision making for people who lack capacity. Staff knew about specific people who had been assessed as lacking capacity. One member of staff told us "People will respond differently at different times to different staff. I get to know their body language so they can understand decisions that people made about their needs." Another member of staff told us, "It's about supporting people to make day to day decisions by themselves." This demonstrated a good understanding of supporting people appropriately where they lack capacity within the principles of the MCA. When people had capacity to make decisions about their care or to exercise choices in everyday matters they were free to do so. Staff asked people for their consent to care. For example, a member of staff asked a person, "Are ready to get up? Would you like me to help you get washed and dressed?" People told us that staff sought consent appropriately before giving personal care. One person said, "They always check before they do anything."

People were supported to maintain good health and received on-going healthcare support. People told us they had access to the GP whenever they needed to, as well as other health care professionals. We spoke to one healthcare professional they told us they found the registered manager worked well in partnership and the clinical care of people was well managed. This professional told us they visited the service weekly and that staff were good at following up as a result of receiving clinical guidance. The service was able to undertake their own blood tests which created a more efficient process liaising with healthcare professionals. Care plans showed that people had regular access to healthcare services such as a GP, tissue viability, chiropody and optician services.

People told us they had enough to eat and drink and were satisfied with the food provided. Breakfast was served in people's rooms and the dining room and people chose where they preferred to eat lunch and supper. The chef was knowledgeable about people's preferences and those who had risks around food and required special dietary requirements such as fork mashable food and soft or pureed diet. People were given food in the right consistency for them and the chef was following current good practice guidance by ensuring meals were fortified and making snacks available for people between meals to ensure sufficient nutritional intake. The chef told us that if people did not care for either menu option, other meal choices

were offered. Where people needed support with eating we saw staff encouraging people and regularly offering drinks.

The decoration and adaptation of the physical environment of the service was sufficient to meet the needs of people. People had access to equipment to support their independence including hoists, individualised slings and wheelchairs when needed. Lifts were available to people to use to access bedrooms on the first floor. Corridors were left clear and accessible to enable people who were independently mobile to move freely and safely.

Good

Is the service caring?

Our findings

There were positive relationships between staff and people who lived at Firgrove Nursing Home, with staff having awareness of each person's needs. People spoke positively about the care they received. One person told us "The staff are very kind." A relative told us they had "a very good relationship" with the registered manager and deputy manager.

Staff had developed positive and caring relationships with people. Staff treated people with kindness and compassion. For example, one member of staff sat with a person who was distressed. The member of staff held and gently stroked their hand, speaking softly to them and engaged them in a conversation about Christmas which visibly calmed the person. Another person was being supported to sit in a chair in the lounge by two care staff and a registered nurse who were using a hoist to transfer the person. Staff checked carefully that the hoist was fitted correctly, ask the person if they were comfortable, staff taking time not to rush the person. They were very gentle with the person and went slowly and safely. They checked the person's position in the chair, and ask if they were comfortable. There was friendly conversation, and laughter between staff and the person. A member of staff asked if the person wanted a coffee and we later observed them supporting the person to drink it.

Staff spoke positively about the people they cared for, knew people well and were familiar with their routines and preferences. One member of staff told us, "We know their quirks and how to make them laugh. It's like a family to us, not just a job." Staff worked at people's pace whilst offering support. Staff chatted with people in a relaxed, friendly manner. We observed positive interactions with staff who were supporting people. For example, we saw one member of staff gave lots of encouragement to one person as they ate, commenting on how well they were doing and was positive throughout.

People were treated with dignity and respect. Staff called people by their preferred name. Staff had awareness of each person's needs and maintained people's dignity during personal care. Staff knocked on people's doors before entering a room and waiting to gain people's consent before supporting them. Where people were able to mobilise independently they were free to move around the home as they wished. People's preferences and choices were considered and supported, for example one person liked to eat poached eggs or an omelette every day and we saw the chef preparing an individual meal for them. The chef told us "I get to know residents very well… they can choose and I'll make it."

People's differences were respected and were supported to maintain their identity and personal and physical appearance in accordance with their own wishes. People were supported to dress in accordance with their preferences or lifestyle choices. Staff ensured that people's rooms were left tidy and clean after any personal care was given. People were free to arrange their rooms as they wished, and many people's rooms were highly personalised with items that were important to them.

Visitors were welcomed. They sat with people in communal areas and private rooms. People's relatives told us staff made them feel welcome at any time. One person had their great grandchild visiting them and told us, "I love having my visits!" Relatives were free to visit people as they wished. One person's relative told us,

"The staff are friendly and kind."

The provider had an electronic care plan system where information about people was stored and updated. Care documentation was held confidentially and systems and processes protected people's private information. There was one computer terminal for care staff to use to update care records and this was located away from the main communal areas. Sensitive information was stored securely in the registered manager's office which was locked when they were not present.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2017 we found people were not always provided with meaningful occupation or activities that were suitable for their needs. There was a lack of evidence about how people's social needs were being met and this was a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the breach of regulation had been met, but these improvements needed more time to be embedded. This key question continued to be rated as Requires Improvement.

After the last inspection the registered manager had developed an action plan to address the issues and employed an activities co-ordinator to improve people's access to activities and meaningful occupation. At this inspection we found this member of staff had left employment in June 2018. However, a new activities co-ordinator had been employed by the service, and the first day of this inspection was their first day in the role.

People had access to some activities but this needed time to be developed further to include everyone living at Firgrove Nursing Home. One person was in a wheelchair and in the conservatory on their own. The person was unable to verbalise their preferences due to their health condition. The person was left in the room for most of the morning. The television was turned on in the room, though it was behind the person out of their sight and a children's program was playing loudly. We bought this to the registered manager's attention. The registered manager told us, as the person was fed by tube and unable to eat, it was felt more dignified for the person to be in a different room away from the sights and smells of the kitchen. The registered manager told us the person liked to sit looking out at the garden, and staff checked on the person regularly. We looked at the person's care plan to see what their likes and dislikes might be, but there was very little information about the person's life history or whether these actions reflected the person's preferences.

Care plans were not always consistent in capturing important information around personal history or people's preferences and likes and dislikes. There was a lack of person centred focus within some care plans that would assist with planning meaningful activities for people. For example, one person's care plan who had dementia stated they were unable to communicate in any way to convey their understanding of information shared with them or the decision they wished to make. They maintained family connections with their children and spouse, who was also the person's Lasting Power of Attorney [LPA] for health and welfare. It was noted that the person's spouse visited regularly up to four times a week. The person's LPA was consulted appropriately for healthcare matters but despite this, and strong family connections, the section in the care plan for hobbies and interests contained no information. There was limited information about the person's likes and dislikes, other than the person lacked capacity to make decisions about activities.

The new activities co-ordinator told us that they were employed five days a week at the home, and had plans to develop an activities program, including individual activities for people who remained in their rooms or were unable to access group activities. People seated in the lounge and dining area were engaged in some activities with the new co-ordinator, such as colouring books and playing cards.

People had access to communal activities at Firgrove Nursing Home. This included a monthly cheese and wine event, picnics in the garden and visits from musical entertainers. Two BBQ's had been held in the summer months, and a newsletter was sent to relatives in August 2018 which showed pictures of relatives and people at the home outside in the garden enjoying the event. Other newsletters showed that people's birthdays were regularly celebrated by the chef baking a cake. There were links with a local college whose music students volunteered every week, which a relative told us people at Firgrove Nursing home enjoyed.

The registered manager recognised that the provision of activities for people was an area that required improvement. The new activities co-ordinator needed to time to work with people and for meaningful activities to be embedded. After the inspection, the registered manager provided us with an action plan on how they intended to address this issue. This included allocating people with a key worker, involving people and their relatives in developing personal histories and life stories to ensure people's interests and preferences are identified in order to deliver a more person-centred approach to care.

People who needed assistance with eating were well supported but not all aspects of the mealtime experience was person centred. We observed lunch on the first day of inspection. The menu was displayed though not everyone could see it. No alternative menus were provided, such as picture menus to support people with dementia to make choices. We noted that both options offered for lunch on the first day of inspection were chicken which gave people limited choice. The soft diet for people with risks around eating looked unappetizing as the food was all one colour, as opposed to each food being separated. Condiments were not placed on the table and these were not offered to people. We saw one example where two people who needed help to eat had to wait until staff had finished assisting other people. Their meals were placed on the table but no consideration was given to keeping the food hot while they waited or arranging two sittings for lunch so people did not have to wait. Lunchtime was unhurried. We observed that people who needed support with eating received dedicated one to one support with this by a member of care staff. Another person was supported to eat independently but at their own pace. Staff supported the person to finish their main course which took them an hour, they were not hurried and the person's dignity was respected to enable them to eat independently. We bought this to the attention of the registered manager as aspects of the mealtime experience needed to improve.

Care was person centred with respect to people's healthcare needs. The provider used an electronic care plan system and this contained detailed information about people. Staff were able to access care plans electronically and received information about peoples care needs through daily handover meetings led by the registered manager or deputy manager. For example, one person had epilepsy and high blood pressure and their care plan contained detailed guidance for staff about what to look out for and what action to take in the event of a seizure, and information about their medicines, including what it's for and potential side effects to look out for. In another care plan for a person living with dementia, there was information to guide staff to ensure there were no mirrors in the person's room as they became distressed at their own reflection which staff were aware of. Two people at the home were diagnosed with Parkinson's Disease and they received support which followed best practice guidance. This included management of their medicines guidance as they were receiving time specific medicines. Records confirmed specific times were adhered to. The registered nurse confirmed that a Parkinson's specialist nurse reviewed medicines for these people every three to six months. One relative told us staff were, "Very good with Parkinson's medications" and that staff always adhered to the specific timing. One relative told us that staff, "Make a real effort" when the person had low points due to their Parkinson's. They told us staff, "spend a lot of time with her, and make her laugh."

Where people needed to raise concerns, the provider was responsive. Learning from complaints was highlighted to staff through the daily handover meetings. The providers complaints procedure to was

available for people and their relatives to view. Staff told us the management were responsive and "They will act on any concerns." A person told us they knew how to raise concerns and had not hesitation to do so. They said, "If I was unhappy I'd go straight to the manager or deputy – they are both very approachable". Complaints were managed in line with the providers policy and we saw a complaints book where appropriate actions were taken and logged.

Staff were aware of people's communication needs. For example, one member of staff communicated with a relative with impaired hearing using appropriate sign language to ensure the person was satisfied with their meal. Care plans showed people's sensory and communication needs were being considered and recorded. We looked at how the provider had incorporated the Accessible Information Standard (AIS) when assessing people's needs. This is the standard that aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Providers must identify record, flag, share and meet people's information and communication needs in line with section 250 of the Health and Social Care Act 2012. All organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards. The provider had a policy in place setting out its legal obligations with respect to AIS.

People were asked about their wishes with respect to end of life care at the time of their initial assessment and this was recorded in their care plan. Staff received training on how to care for people at the end of life. At the time of this inspection the provider was not supporting people with end of life care.

Inadequate

Is the service well-led?

Our findings

At the last inspection in September 2017 shortfalls were identified in the provider's systems for monitoring standards and quality at the home and this was a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider produced an action plan in order to address the issues but despite this, at this inspection we continued to find issues with quality monitoring and management oversight of some aspects of the service. This demonstrated a lack of embedded governance framework and this key question has deteriorated to Inadequate.

The registered manager did not have oversight of quality assurance systems designed to identify shortfalls and drive improvements. The registered manager had processes in place to monitor standards and quality of care. This included regular audits such as an infection control, medicines administration, health and safety, care plans and staff files but these were not effective.

Audits of staff files did not ensure that all appropriate recruitment checks were completed to assess whether staff were suitable to work with the people. The registered manager undertook an annual audit of all staff files but this had not ensured all nursing staff had clinical registrations with appropriate professional bodies where necessary. One member of staff had been working in a significant nursing role without appropriate clinical registration for two years. The registered manager was unable to provide an explanation for this omission. While we did not find evidence of actual harm, this exposed services users to the potential risk of harm from receiving nursing care from a person who may not be fit or competent to do so. Furthermore, records showed that while checks had been made with the Disclosure and Barring Service (DBS), not all were applicable to working at Firgrove Nursing Home. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. The registered manager had not properly carried out all necessary recruitment checks to ensure service users were cared for by fit and proper persons. We asked the provider to take immediate steps to ensure people's safety.

There was no organised system of record keeping to support the registered manager's oversight of safety and maintenance. Some records were incomplete. For example, regular water temperature checks were undertaken, but there was no evidence of Legionella testing in the last five years. A maintenance and grounds audit on 18 August 2018 stated the boiler had been serviced by an appropriate contractor and records were kept. The gas safety certificate on file was dated June 2017 and was overdue. The registered manager organised a gas safety engineer to visit the home on the second day of inspection. A health and safety audit of 18 August 2018 stated that fire drills had taken place with the last six months for day staff and three months for night staff, however there were no records for fire drills to show when these had taken place. A lack of documentation around fire drills was also found at the last inspection in September 2017. This demonstrated a lack of managerial oversight and meant that the registered manager could not be assured that the premises were compliant with all safety standards.

Audits of care plans did not always identify inconsistencies in documentation. For example, an audit had been completed on 18 August 2018 stated that people's recreational preferences were recorded in the care plan, and activities were planned in accordance with individual preferences. However, there were limited

details about people's preferences in the care plans and no evidence provided of how activities were planned around people's interests. The same audit also recorded that staffing levels were maintained and planned well, but there was no evidence of how staffing levels were calculated and had not identified that staff deployment was not always meeting people's needs.

There was no robust system to support registered manager with oversight of training for staff. The registered manager kept a list of training courses for the year that the provider considered essential for staff. Attendance sheets were signed by staff when they had completed training, and this was sometimes the only record retained. These records did not always correspond with the training calendar or information in staff files. For example, the training calendar stated dementia awareness training was held on 02 March 2018, but there was no evidence to confirm training had been delivered and which staff had attended. It was unclear how the registered manager was tracking training requirements and timeframes. There was no system to track which courses had been completed by staff and which were overdue.

These continued shortfalls in quality assurance systems demonstrated the provider did not have an embedded governance framework. There was a continued failure to assess, monitor and sustain improvement in the quality and safety of the service and this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was actively involved in the day to day management and culture of the home and demonstrated they had a good understanding of the needs of people they were supporting. Staff told us that they felt the registered manager was easy to talk to and felt the home had good leadership. One staff member said, "They always support the staff." Another staff member told us, "I think it's a very good team." There was a clear management structure with identified leadership roles and staff understood their responsibilities and knew what was expected of them. There were clear policies and procedures to support staff in their roles. The provider emphasised treating people with respect and maintaining their dignity and privacy. One staff member told us, "As a company, they look after residents." These values were understood by staff and we observed this in practice.

Communication within the staff team was good and staff reported feeling well supported and motivated. One staff member said, "Staff work well together." Staff communication was managed mainly through daily handover meetings that were led by the registered manager or deputy manager. We observed a handover meeting where communication between staff was effective. The registered manager understood the needs of people living at Firgrove Nursing Home and there were professional and respectful relationships with staff.

Staff continued to work in partnership with other organisations to ensure people's needs were met. The registered manager and staff had developed relationships with a variety of healthcare professionals including GP's, tissue viability specialist nurses, chiropody and optician services.

The registered manager understood their responsibilities in relation to the Care Quality Commission (CQC). They could describe the types of incidents that required notification to us, for example such as safety incidents or safeguarding concerns. It is a legal requirement that a provider's latest CQC inspection report is displayed where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. At the time of the inspection we found the provider had met this requirement by conspicuously displaying their CQC rating within the home.

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 17 HSCA RA Regulations 2014 Good governance Failures in some systems for monitoring standards and quality at the home had led to a lack of management oversight in some areas of practice.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes and ongoing monitoring did not always ensure all appropriate checks were completed and all staff were registered with the relevant professional body to ensure fit and proper persons were employed in order to keep people safe.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was no systematic approach to determine staff deployment in order to meet all people's needs.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.