South West Care Homes Limited

The Firs

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Firs is a residential care home that was providing personal care to 24 people aged 65 and over at the time of the inspection; some of whom were living with dementia. Four people were on short stays. The home is registered for 28 people. It is owned by South West Care Homes Ltd who own and manage eight other care homes in the South West.

People's experience of using this service:
Quality assurance arrangements were weak, and problems were not always identified or addressed in a timely manner. Since our last inspection, the standard of record keeping, auditing and the safe running of the home had declined. Staff said poor quality audits of the service, a lack of investment, a lack of office time for the manager and staff vacancies were contributing factors.

Some areas of the home were poorly maintained, unsafe and odorous. Staff practice showed a lack of understanding of good infection control measures. Systems had not been put in place to ensure commode pans were emptied and washed in a safe manner to prevent the risk of cross infection. Three bedrooms had an odour of urine. Cleaning fluids had been left in two communal bathrooms and the door to the laundry and the sluice area was left unlocked which put people living with dementia at potential risk of harm. A large sofa in the conservatory had stained seat cushions.

Checks to ensure people were protected from scalds from hot water were not meaningful. When the hot water was above the recommended temperature, there was a poor audit trail to show how the risk had been managed to protect people from harm. Radiators in two bedrooms were uncovered. One person's heavy bedroom door shut so rapidly they were in danger in being knocked over; they were frail and used a frame to walk. Neither, the door opener system or the door closure fitting were working correctly.

There were areas of the home in a poor state of repair, for example worn carpets taped to prevent a trip hazard, loose cabling, as well as chipped paintwork. There were leaks in the conservatory roof, the water dripped onto the carpet in three places and the carpet was wet. Flooring was stained or ripped around some toilets. One person's bedroom ceiling was heavily stained due to a leak from the room above. Some bedrooms were poorly lit, which could put people at increased risk of falling.

Following the outcome of an individual safeguarding concern, action to show lessons had been learnt had not been taken promptly.

Many areas relating to care needed to be improved, including people not signing their care plans to show their agreement. There were examples of poor moving and handling by some staff. There were gaps in staff training, including medicine administration and fire safety. There was poor oversight of staff hours; one staff member was working excessive hours which had not been addressed.

Care plans and risk assessments were reviewed on a regular basis. The quality of these reviews was variable,

mistakes had been made in the completion of some assessments, so they were inaccurate. However, this had not impacted on how the risk was addressed by staff.

The organisation was reviewing how peoples' well-being and interest were met. They recognised some elements of their current provision was not suitable and were expanding the quality and choices available to people.

Staff were not recording concerns formally and therefore the complaints process was not being followed. There had been a lack of effective oversight and governance of the service, which did not support the delivery of high-quality care. The culture of the provider was not always open and transparent. People living, working and visiting the home had not been formally told of changes to the way the organisation was being run.

The provider had recruited a new team of operational staff. It was too early to see the impact of this new approach. However, since the inspection we have received timely assurances regarding action taken to address concerns.

People were positive about their experience of living at the home. They looked relaxed and at ease with staff. Staff could explain how they supported people and understood how they contributed to their health and wellbeing. For example, "I have nothing but praise for the staff, they always keep half an eye open. I can't complain. Sometimes I need to get up quickly to the toilet, they always respond."

Staff relationships with the people they assisted continued to be caring and supportive. People's nutritional needs were met, and people praised the quality of the food. A visitor said, "I feel the atmosphere is pleasant, they care about people." Staff spoke confidently about the care they delivered and affectionately about the people they supported. They understood how they contributed to both people's physical health and mental wellbeing.

Staff praised the approachability of the manager and were happy with the level of team work. They said the manager was a good role model as they were "relaxed and happy with residents." Other staff described the manager as "kind" and "compassionate." Staff said they enjoyed working at the home.

Rating at last inspection: Requires Improvement (report published in April 2019).

Why we inspected: This inspection was scheduled for follow up based on the last report rating.

In November 2017, a focussed inspection was completed following a safeguarding concern. The service was rated as Requires Improvement. Two previous inspections in 2016 and 2017 had been rated as Good.

In July 2018, a comprehensive inspection took place following the service becoming part of a whole service safeguarding and an individual safeguarding process. This meant the local authority safeguarding team, commissioners, CQC inspectors, police and other professionals had met to discuss the safety and well-being of the people living at the service. The provider, their operations team and the previous registered manager had been part of these discussions. Both of these alerts were closed based on the improvements and actions taken to address concerns identified. CQC are continuing to look at the circumstances surrounding an incident involving one individual.

During the inspection in July 2018, we found staff spent time with people and there was a low risk of social isolation. However, people were not always enabled to take part in meaningful activities on a regular basis.

The overall rating was Requires Improvement with one breach.

In April 2019, the service was rated as Requires Improvement for a third time but this time there were no breaches.

In September 2019, there was an individual safeguarding concern raised for a person living at the home. A multi-disciplinary meeting was held, and actions were agreed to address concerns arising from the investigation.

In September 2019, a new nominated individual began working for the provider. Their role includes Director of Operations; they have a team of four staff with their own quality assurance responsibilities. These include maintenance, care planning, activities and community involvement, training and overall quality assurance. CQC have met with this new team in October 2019 and will continue to meet with them every six to eight weeks to discuss the operation and regulation of the nine homes registered with the provider.

On this inspection, we judged there had been five breaches of regulation in relation to infection control, safe care and treatment, maintenance of the building, staff training and governance arrangements. We also made a recommendation as to how oral hygiene was provided.

Special Measures
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement
procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Action we have taken: CQC have taken enforcement action by imposing a condition on the provider's registration. This requires the provider to provide CQC with a monthly report outlining actions and progress in making the required improvements.

Follow up: We will continue to monitor the intelligence we receive about the service. If any concerning information is received, we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Firs

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one adult social care inspector, a member of the medicines team 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.

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

What we did: Before the inspection, we reviewed relevant information we had about the service, including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events, which the provider is required to tell us about by law. We checked the last inspection report and contacted the local authority for information.

The service completed a Provider Information Return (PIR) prior to our last inspection. A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make.

During the inspection, we spoke with 20 people living at the home, six visitors, six staff members, the manager, the nominated individual and members of the operations team. Most people using the service were living with dementia or illnesses that limited their ability to communicate and tell us about their experience of living there. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us and share their

experience fully. We reviewed people's care records, including assessments, staff files, rotas, timesheets, records of accidents, incidents and complaints, audits and quality assurance reports. We reviewed 14 people's medicine administration records. We observed administration of medicines and checked storage arrangements, policies and procedures, medicines audits and records.

We contacted health and social care professionals. We reviewed a report by the local authority's quality assurance and improvement team.

After the inspection
We provided detailed written feedback to the nominated individual. They provided an update on the actions they had begun to take to address concerns. We will request a formal action plan from the provider where they can demonstrate what they will do to improve the standards of quality and safety.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
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At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

Preventing and controlling infection

- Staff practice showed a lack of understanding of good infection control measures. For example, they wore gloves in communal areas; these are used when staff provide personal care to people. The manager confirmed there was no infection control champion amongst the staff group.
- Systems had not been put in place to ensure commode pans were emptied and washed in a safe manner to prevent the risk of cross infection. There was no sluice in the home; staff emptied used commode pans into the toilet of a communal bathroom and then rinsed them in the bath, which was not currently in use. There was no soap or soap dispenser in this bathroom. There was no written guidance for staff on how to empty and clean commode pans safely. After the inspection, we were told new guidelines were being introduced.
- Three bedrooms had an odour of urine. Staff said two bedrooms had long term on-going odour problems despite cleaning the carpets and in one room the flooring had been replaced with a specialist carpet but there was still an odour. After the inspection, the nominated individual said these rooms had now been deep cleaned and new carpets had been ordered.
- At our last inspection in March 2019, the manager said work was planned to improve the laundry arrangements to address the current layout to ease cleaning the area and promote better infection control measures. Improvements to a communal bathroom had been prioritised over the laundry. The laundry area had flaking paint on the walls and holes around electrical fittings making it impossible to clean thoroughly. Work was planned to begin in December 2019 after quotes had been compared.
- During the first day of inspection, the door to the laundry was left unlocked. This put people living with dementia at potential risk of harm and we raised this with the manager on both days. The door remained unlocked on occasions during the second day. We were told staff would be reminded again and action would be taken to ensure the door automatically shut.
- A large sofa in the conservatory had stains and food on the cushions. This was the case on both days of our inspection. After the inspection, we were advised the sofa cushions and covers had been washed.
- There were unpleasant marks on the wall beside one bed. This was the case on both days of our inspection. After the inspection, we were told this was being addressed.
- Slings were not routinely labelled, but because only a few were used, and they were different sizes, staff were able to identify them and ensure they were only used for each individual. However, there was no identification system in place should the numbers of slings of the same size be in use.

Assessing risk, safety monitoring and management

•□Checks to ensure people were protected from scalds from hot water were not meaningful. When the hot water was above the recommended temperature, there was a poor audit trail to show how the risk had been managed to protect people from harm. A guidance sheet on how to check hot water temperatures in people's bedrooms provided unclear instructions for staff completing this task. Operational staff said this had recently been recognised as being unclear and would be addressed. One sink did not have a working temperature regulating system; a risk assessment had not been completed to manage the potential risk of scalding. After the inspection, the nominated individual said a new weekly checklist had been introduced and a new temperature regulating valve fitted.

•□In June 2019, an audit identified radiators in two bedrooms were uncovered. This had not been addressed, despite one person being at high risk of falls. We were told this would now be addressed as a high priority.

•□Cleaning fluids had been left in two communal bathrooms which put people living with dementia at potential risk of harm. These were removed once we highlighted the risk and lockable cupboards put in place for storage.

•□A new member of staff had been given the role of checking the safety of bed rails; they ticked to show they had done this. However, there were no records to show if their practice followed current best practice guidelines and how they had been inducted. A member of the operations team met with them following the first day of inspection to provide guidance on their role. We were told training would be arranged.

•□One person's heavy bedroom door shut so rapidly they were in danger of being knocked over; they were frail and used a Zimmer frame. They were assessed as at risk of falls. Neither, the door opener system or the door closure fitting were working correctly. This put the person at increased risk of falls as they tried to manoeuvre in and out the room. The door was fixed as a result of our feedback.

The provider had not addressed and audited identified risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Window restrictors were in place and fire equipment was checked at appropriate time scales.

•□Risk assessments identified when people could be at risk of harm and the action to be taken by care workers to minimise the risks. Individual risk assessments in the care records covered people's physical and mental health needs. Recognised national assessment tools were used to monitor people's health risks, for example malnutrition. People's weights were monitored, and records showed the checks were increased to weekly if people identified as at risk of malnutrition. Records showed health professionals had been contacted for advice.

•□Staff understood the risks to people's health and their safety and supported them in a way to help reduce these risks. For example, acting on the outcomes of risk assessments to reduce people's risk of pressure damage by ensuring pressure-relieving cushions were consistently used. Staff placed a wedge between one person's knees to prevent skin damage, which followed the guidance in their risk assessment.

•□Staff said there were no regular altercations between people living at the home, which was confirmed by a lack of incident reports. People said they felt safe and if they had a problem they would call for staff.

Learning lessons when things go wrong

•□There was not a proactive response to learn from the outcome of a recent individual safeguarding meeting which looked at the events around a person falling. This had taken place three weeks prior to our inspection; an action plan was agreed. This included a clear and visible sign to be put near the call bell in the lounge so that people could call for assistance. This had not happened; we were told this would now be addressed. When we returned on the second day, no sign had been put up, but two pendant call bells had been put in reach of people to request help. However, conversations with two people about the purpose of

the pendant call bell showed they did not understand its use, and one person struggled to use it. The manager said they had been shown how to use the pendant call bell on a previous day. During the last CQC inspection in March 2019, we had highlighted the lack of an accessible call bell in the lounge and conservatory area, action had not been taken.

• The safeguarding meeting also addressed the seating arrangements for one individual, which put them at risk. During our inspection, a person was sat in a chair by staff and could not place their feet on the floor. Their assessment showed they were at risk of pressure damage, including to their feet. This showed lessons had not been learnt following the recent safeguarding meeting. For example, reviewing people's seating arrangements and the suitability of chairs for each individual. Prior to the inspection, staff had asked the community rehabilitation team to visit; they confirmed a footstool or pillow was needed.

The provider had not addressed identified risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• An internal audit in July 2019 identified some pressure relieving mattresses were not set correctly, which put people at risk of pressure sores. We saw pressure-relieving mattresses were now set correctly to correspond with people's current weight, which helped support people from pressure damage.

Systems and processes to safeguard people from the risk of abuse

• Staff had been trained on safeguarding people from abuse and knew they could report concerns both within the service and to external agencies.

• One person's records showed they had not had access to their own money for several months despite requests from staff members to their family to resolve this issue. A safeguarding referral had not been made; we highlighted this delay to the nominated individual who said this would be addressed. After the inspection, a relative provided the requested money when they were contacted again by staff.

• People said they felt safe in their rooms and in the communal areas. One person said, "Staff look after me, I have to get up in the night, they come and take care of me, I was having falls at home, here they look after me, I ring my bell, they come quickly." A person who lived in the bungalow which is separate from the main building said, "They come over and check us during the evening and at night, there is nothing I would change, nothing has happened that would want me to change anything."

Staffing and recruitment

• Recruitment procedures ensured necessary checks were made before new staff commenced employment. The manager ensured relevant references for new staff, for example from previous employers in care, were requested. Disclosure and barring service checks (DBS) were carried out to confirm whether applicants had a criminal record and were barred from working with vulnerable people. However, an explanation for a gap in one person's employment history and a risk assessment to show how their suitability had been assessed for their role had not been recorded. The manager said this would be addressed with the individual.

• Staff rotas for four weeks showed the manager had worked team leader shifts and had also worked as part of the care team. For example, eight shifts as a team leader, which were 12 hours long. And three shifts as a care worker, which were also 12 hours long. This additional work impacted on their ability to complete managerial tasks. Since the inspection, additional staff had been arranged, which enabled the manager to return to their managerial role.

• One care staff member had worked 72 hours one week and 60 hours on the following week. The manager said this was because the staff member chose to work these hours but consideration had not been given to the potential impact on their practice and people's safety and well-being. Since the inspection, additional staff had been arranged to support the existing team.

•□Staffing levels were only maintained because of the manager taking on additional duties. Some shifts also ran with no cleaning support, or reduced numbers of cleaning staff.
•□There was a vacancy for a team leader. Two new care staff members had recently been recruited; a long-term agency member of staff had left unexpectedly. Long term staff sickness and annual leave had also impacted on staffing arrangements over August and September 2019. One person commented, "I have no complaints about the staff whatsoever, they are caring and kind, they haven't got much time, when they have they talk to me."
•□Staff were positive about the recent addition of a fourth care staff member in the mornings now that the number of people living at the home had increased.

Using medicines safely
•□People received their medicines safely, and records showed they were given in the way prescribed for them.
•□Some improvements had been made as recommended at our previous inspection in March 2019. Guidance was now in place for staff to make sure any medicines prescribed to be given 'when required' were administered to people when appropriate. Any handwritten amendments to people's medicine records were checked and signed by a second member of trained staff, in line with good practice guidance.
•□Guidance was available for care staff to be able to apply creams and other external preparations correctly, and records showed when these were applied. On some occasions staff recorded that 'cream' was applied rather than the named product. Managers told us they would review this with staff as necessary.
•□There were suitable systems in place for the storage, ordering, administering, monitoring and disposal of medicines. Storage temperatures were monitored to make sure medicines would be safe and effective.
•□Day staff received medicines training and competency checks had been completed to make sure they gave medicines safely.
•□ Regular medicines audits were completed. These identified any necessary actions which were put in place to improve the way medicines were managed.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs

- There were areas of the home in a poor state of repair, for example worn carpets and chipped paintwork. There were leaks in the conservatory roof, the water dripped onto the carpet in three places and the carpet was wet. This was in a communal area used daily by people living at the home as there was limited seating in the lounge.
- Staff said had been a problem since at least February 2019. The nominated individual said there had been several repairs carried out on the conservatory roof during 2019. However, they said it was not apparent the repairs had not worked until a heavy downpour and directional winds highlighted the problem continued. Because of the leaks, the main light fitting had been moved. After the inspection, the nominated individual said a temporary repair had been made to the roof, and a full repair was planned for Spring 2020 when they hoped the weather would be warmer.
- Flooring was stained or ripped around some toilets. After the inspection, the operations manager said quotes were being gained to replace flooring.
- One person's bedroom ceiling was heavily stained; we were told this was due to a leak from the room above. After the inspection, we were told contractors had addressed this issue.
- Some bedrooms were poorly lit, which could put people at increased risk of falling. After the inspection, we were told daylight bulbs would be trialled.
- There had been different managers who had each introduced changes to the environment which had resulted in a mix of styles. For example, numbered bedroom doors in a mix of different colours. There were no other distinguishing features to help people identify their rooms. Some people were only able to distinguish their own room by opening the door to check inside. There was the potential they could open the doors to other people's rooms by mistake. For example, "A man along the passage comes to my door, I just ring my bell, it has happened a few times at night, it's not a problem."
- Since our inspection in March 2019, a gate had been removed from a small flight of stairs. Gates still remained at the top and bottom of the main flight of stairs. The environmental risk assessment did not clarify why these were needed. During the day there was mixed advice from staff as to whether the gates needed to be locked. The director of operations and the manager said the need for the gates would be reviewed.

The provider had failed to ensure the environment was properly maintained, which was a breach of Regulation 15 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

•□The décor of the downstairs communal wet room had been updated to make it a lighter and more attractive space. One communal toilet had been moved to give people using a frame more space to manoeuvre. However, the upstairs communal bathroom which contained a toilet was gloomy because there was no natural light and poor lighting.
•□The lounge had been re-decorated, and work was taking place to decorate the dining room. It had previously had a themed style but was being returned to a more traditional style dining room.
•□Work was in progress to make the garden more accessible to people living at the home. Future plans being considered were to provide a theme, such as sculptures or a sensory garden, to encourage people to explore the whole area. However, this was work in progress.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

•□People had not signed their care plans to show their agreement with the content.
•□During a safeguarding meeting in September 2019, relatives of a person living at The Firs said they had not been involved in developing their relative's care plan. During the inspection, the manager acknowledged they needed to ensure people signed their care plans to show their agreement with the content. They said this had been achieved for one care plan.
•□There were DoLS applications that did not include the fact a sensor mat was in place to alert staff if the person got out of bed at night. One person's records contained inconsistent information linked to their capacity to decide where they lived. We were told these records would be reviewed. No DoLS applications had been approved yet.

The provider had not ensured consent was gained from the relevant person which was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).

•□The registered manager checked if relatives had the legal authority to be involved in decisions relating to health and welfare or finances. This meant people's legal rights were protected.
•□People looked relaxed and at ease with staff. Staff could explain how they supported people and understood how they contributed to their health and wellbeing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
•□The manager completed pre-admission assessments before people moved to the home, which included dates that were important to them. For example, marriage or bereavement dates. However, the assessments did not show who had been involved. This additional information had already been recommended to the manager by the local authority's quality assurance and improvement team in July 2019.
•□The manager said people were encouraged to visit before moving to the home. Following discussion with operational staff, they decided to create a clearer audit trail about who visited the home. And if people were given this option but had delegated the visit to another, for example a family member, this would be

recorded. One person, who used a Zimmer frame, had recently moved to the home, their room was smaller and less accessible than most of the rooms. After the inspection, operational staff said the person had been offered and accepted an alternative room.

Staff support: induction, training, skills and experience

• Staff confirmed training was available, through DVDs or practical training. On our last inspection in March 2019, some staff had not yet completed training in dignity, respect and equality and diversity which the service identified as key training. This had been identified by the manager and plans were in place to deliver this training over the coming weeks. The training matrix showed up to 13 staff members were still waiting for training in these areas.
• Rotas showed there were night shifts which ran without a staff member being trained to administer medicines. For example, in one week there were six shifts without a suitably trained member of staff, which could potentially impact on people receiving pain relief. The nominated individual said training would be completed by the end of October 2019, followed by competency checks. In the meantime, they said a member of staff trained in medicine administration, who lived locally, was on call.

The provider had not ensured staff were suitably trained, which was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

• During the first day of inspection, a person was moved in an unsafe manner. We shared this risk with the Director of Operations who confirmed the staff member had been trained but following our feedback attended a refresher course. The staff member's moving and handling training was in date but they were not working in a safe way.
• Another person living at the home described how they were helped to move in bed by another staff member. We shared our concerns about the staff member's practice, which we were told would be addressed. The staff member's moving and handling training was in date but they were not working in a safe way.
• A person was found on the floor of their room; they described how they had been assisted to get up from the floor. Staff completed records after this incident, but they did not accurately reflect what help had been provided. The manager said they were not aware of this discrepancy. We were told this would be addressed with the staff members involved. On the second day of the inspection, staff statements were being collected.
• A new training manager had been employed by the provider to address training issues across the care homes' group.
• Staff said they were supported through team meetings and supervision.
• Staff shared information to ensure people received consistent care and risks were monitored. This information was both verbally and via communication books and electronic records. Staff said they did not always have time to check individual's care records so relied on handovers to update their knowledge.
• Staff new to care completed a nationally recognised induction qualification.
Supporting people to eat and drink enough to maintain a balanced diet
• Care plans were not consistently completed regarding people's preferences. However, staff knew people's food and drinks preferences as shown by their conversations.
• People's nutritional needs were met. People praised the quality of the food. For example, one person said, "The food is very good, excellent." Another person said staff bought their preferred yoghurt.
• At lunch time, staff showed people the menu by bringing out the choices on a plate, which was good practice to help people living with dementia make an informed choice. There were two choices for the main course and dessert. Cheese and biscuits were also available. There was a range of drinks served at lunchtime, and drinks were available in the dining room area for people to help themselves. Staff supplied

drinks throughout the day; some people regularly requested a hot drink and staff were quick to respond.
•□15 people sat in the dining area for their lunch. They ate in a leisurely manner without being rushed; people were supported with their meal by attentive staff. Other people said they preferred to eat in their rooms.
•□Staff recognised when people's physical health needs changed and impacted on their swallowing. They requested speech and language health professionals to assess how people should be supported to eat and drink safely.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•□Some people required support with oral hygiene to clean their teeth or their dentures. Records were poorly completed. For example, one person according to records, had not received support with cleaning their teeth for four days. After the inspection, the nominated individual said a new programme of care would be introduced to address these discrepancies.
We recommend that the provider should seek advice from a reputable source regarding good oral health care practice, particularly for people living with dementia.
•□Staff recognised changes in people's health and requested an assessment from health professionals. For example, when people lost weight or when people's skin became vulnerable to pressure damage. The manager and staff at the home worked closely with health professionals, following their advice and ensuring appropriate equipment was in place.
•□A GP said there was excellent communication with staff at The Firs and a protocol had been drawn up to help aid their relationship.
•□Routine medical appointments were generally made by staff on people's behalf. Records showed staff worked with a range of community professionals to maintain and promote people's health.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity;
Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Staff did not always ask for people's consent before they provided care or support. For example, some staff did not gain people's consent before placing protective clothing around them at mealtimes. On another occasion, a staff member moved a person in a wheelchair without checking with them. They tucked in their arms without speaking to them and spoke over their head to another staff member.
- Planned staff training to raise their dignity and respect awareness had been delayed.
- There were a few occasions when staff practice undermined people's dignity. There were instances when staff practice undermined people's independence at mealtimes by not ensuring people's food was served so they could eat independently. For example, one person struggled to eat because their meal required needed to be cut up but they could only use one of their hands.
- On two occasions, foot care was provided in communal areas, including the lounge and the main hall. We informed staff whose response showed they had not considered each person's privacy or the impact on others around them.
- Odorous rooms did not support people's dignity.
- However, staff relationships with people using the service were caring and supportive. For example, one person said, "I like people around me 24/7, they are very kind, they help me out."
- Our observations and conversations with staff provided many examples of their commitment to supporting people in their preferred manner and respecting their privacy.

For example, staff practice maintained people's dignity by discreetly checking with them if they needed support to use the toilet. One person said, "It's wonderful, everything in general, the food, the kindness, the help, I couldn't wish for anything more. Everything I ask for, if it's possible they do it. They give me an all over wash, clean clothes, I'm kept spotless and comfortable."

- Several relatives commented on the understanding of staff when they supported people living with dementia. For example, "The staff care for (X) really well, I'm very pleased. Staff are friendly and willing. He can be tearful when his memory fails, they reassure him…in the past 12 months he has come alive." Another visitor said, "Couldn't wish for a nicer team of people" and "Every time I walk away I feel good."
- People felt included and drew comfort from the staff knowing them well. For example, "The staff are very helpful, wonderful. I really like this place. It has a positive approach which you cannot beat. They even cooperate with some of my funny ideas. I find this place very comfortable." And another person said, "It's very nice here, the staff are kind..." A relative commented, "He has a smile on his face, he is happy here."

•□People were treated as individuals; they were relaxed and at ease. Staff knew how to reassure people when they became anxious. Staff said they did not always know if people's anxieties were based on past life events, but they treated people's concerns seriously, taking time to listen to them and reassure them.
•□The atmosphere was welcoming; a visitor said, "I feel happy that he is here. At home he was on his own for hours, he loves it here, he's in a good place."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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

This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•People received personalised care and support specific to their needs and preferences. However, there was not a consistent approach to recording people's life history information; the manager said this was work in progress. Care staff conversations with people showed they knew people well and what topics would interest them.
•Care plans and risk assessments were reviewed on a regular basis. The quality of these reviews was variable, mistakes had been made in the completion of some assessments, so they were inaccurate. However, this had not impacted on how the risk was addressed by staff.
•Care staff said they were kept up to date about changes to people's care needs through verbal and written handovers; they said the manager and senior staff kept them up to date about changes to people's care.

Improving care quality in response to complaints or concerns
•Since the last inspection, there had been one complaint, which the manager was in the process of recording, and had been resolved. However, during the inspection, we saw complaints had been recorded in a team communication book linked to a room being unclean and incontinence pads bought for one person being used for others. This indicated staff were not recording concerns formally and therefore the complaints process was not being followed. The nominated individual said this would be addressed in team meetings and supervisions.
•People and visitors said the manager was approachable. A file which was kept in each person's room contained the home's complaint procedure, which included timescales and contact details.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
•The organisation was reviewing how people's well-being and interests were met. They recognised some elements of their current provision was not suitable and were expanding the quality and choices available to people. This was reflected in some people's feedback, for example, "I join in with activities but there is not enough going on."
•The noticeboard in the hall to inform people of social events was blank on both days of our inspection but we heard people being encouraged to join music sessions in the lounge on both days. Staff said they were reviewing the quality of some existing provision.
•A new member of staff who was focussing on people's well-being had only been in post for a short period of time but was already making contacts with local community groups. They were realistic about the

amount of work needed to ensure everyone's needs were met, including those who chose not to leave their room. The manager and staff praised the new staff member's energy and innovative ideas; they were confident their role would have a positive impact on the lives of people living at The Firs.

End of life care and support

•□At the time of the inspection, nobody was receiving end of life care. The training matrix did not show staff had received training in this area. People's wishes about the end of their lives were recorded in their care files where these were known. However, statements were often generic and not personalised. The manager said this was work in progress and training was being arranged. Some people also had a treatment escalation plan, known as a TEP, agreed with their GP. This covered what treatment the person wanted in case of a sudden deterioration in their health, including their wishes regarding resuscitation or medical treatment to prolong their life.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

•□An audit in August 2019 highlighted there was a communication plan in place in the sampled care plans but more detail was needed to personalise the information.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a lack of effective oversight and governance of the service, which did not support the delivery of high-quality care.
- The registered manager left the service in July 2018 after working for ten months at the service. A new manager started in September 2018; they moved to another of the provider's services in February 2019. The current manager started at the home in March 2019. They have provided management cover in the past at the home and worked as part of the provider's quality assurance team so knew the home well. They have applied to register with the CQC.
- Quality assurance arrangements were weak, and on-going problems were not always identified. The standard of record keeping, auditing and the safe running of the home had declined. Staff said poor quality audits and a lack of regular audits, a lack of investment and staff vacancies were contributing factors.
- The manager covered care shifts, alongside their manager role. On the second day of the inspection, the nominated individual met with a company providing agency staff. Their aim was to use a consistent group of agency staff until permanent care staff could be recruited to enable the manager to concentrate on the running of the home.
- The manager had approved a hot water audit in 2019 but had not acted on the reported problems so the audit was not effective. They had completed care plan audits in August 2019, which highlighted work was needed to improve them by increasing the level of detail, for example life histories. The manager said because they have been covering team leader and care shifts, their time to address managerial tasks had been reduced.
- The manager had not considered the potential risks to people's safety by one member of staff working excessive hours each week and had not discussed this arrangement with operational staff.
- An environmental audit in June 2019 completed by a former member of the operations team covered general issues, cleaning, care planning and the outside area of the home. This audit had 116 action points to be completed. There were 49 actions labelled as urgent with only 25 marked as completed four months later. We asked for a copy of the environmental audit completed prior to June 2019 to help us judge why there was so much incomplete work, but one could not be found.
- Work still outstanding, included the leaking conservatory roof. Work marked as completed, for example door guards, was not always robust as one door was still faulty.
- The nominated individual said the provider had made significant investment in the building. For example,

the refurbishment of the exterior and roof , most rooms had new furniture and specialist beds, the downstairs bathroom had also been refurbished, and flooring had been replaced. However, it was clear from our inspection findings that in some cases an ineffective approach to solve problems and maintain standards had led to areas to some areas requiring improvement.

•□We asked for copies of quarterly audits for the service by a member of the operations team, which included the environment, staffing and audits; only one could be found, which took place in August 2019. There were actions for completion by August and September 2019; a number had not been completed, for example training issues.

•□Consideration had not always been given to the potential impact on the people's well-being and safety. For example, issues linked to infection control.

•□Action had not been taken to address complaints not being recorded appropriately and to raise staff awareness to recognise complaints. Steps had not been taken to ensure complaints were logged and responded to appropriately in line with the service's complaints process.

The provider had not ensured there were effective governance in place, which was a breach of Regulation 17 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

• In September 2019, a new nominated individual began working for the provider. Their role includes Director of Operations; they have a team of four staff with their own quality assurance responsibilities. These include maintenance, care planning, activities and community involvement, training and overall quality assurance. CQC have met with this new team in October 2019 and will continue to meet with them every six to eight weeks to discuss the operation and regulation of the nine homes registered with the provider.

•□Action was taken during or after the inspection once concerns were highlighted and the newly appointed operations team were keen to improve the environment and the experience of people living at the home.

•□The registered manager was aware when to notify the Care Quality Commission regarding serious injuries or death. We used this information to monitor the service and ensured they responded appropriately to keep people safe. However, the leaking conservatory roof had not been reported.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

•□The culture of the provider was not always open and transparent. People living, working and visiting the home had not been formally told of changes to the way the organisation was being run. For example, the introduction of a new operations team and nominated individual. This meant they were not always sure who people were when they visited the home. When the previous manager had left, some family members said they had only found out by chance.

•□Relatives praised the approachability and caring nature of the new manager, for example, she is "very nice, we get on well with her, she is very attentive." People visiting the home said staff kept them up to date with changes to their relative's health and well-being. Some staff were named as being particularly caring and supportive.

•□There was a system which enabled relatives to access some areas of the electronic care records. This meant they could monitor their relative's care when they were away and unable to visit; they felt reassured by this access. However, one relative did comment there had been a considerable delay before they could access the site, despite repeated requests, prior to the current manager's appointment.

•□The manager was visible around the home and people knew them and were at ease with them. The manager had included people in choosing paint colours for the lounge.

•□Staff praised the approachability of the manager and praised the level of team work. They said the manager was a good role model as they were "relaxed and happy with residents." Other staff described the

manager as "kind" and "compassionate." Staff said they enjoyed working at the home.

• The service worked with health and social care professionals to meet people's specific needs. Staff described a good working relationship with health professionals; care records showed this positive relationship had benefited the people living at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Our conversations with staff, the deputy and the manager showed people protected under the characteristics of the Equality Act were not discriminated against. The Equality Act is legislation that protects people from discrimination, for example on the grounds of disability, sexual orientation, race or gender.

• Training was planned to ensure staff completed courses linked to respect and dignity to enhance their skills.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use services and others were not protected against the risks associated with a lack of consent of the relevant person.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment.

The enforcement action we took:

We imposed a positive condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and poor infection control.

The enforcement action we took:

We imposed a positive condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated with a lack of robust governance.

The enforcement action we took:

We imposed a positive condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services and others were not protected against the risks associated with staff who were not trained or had not undertaken refresher training.

The enforcement action we took:

We imposed a positive condition on the providers registration.