Firlawn Nursing Home Limited

Firlawn Nursing Home

Inspection report

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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?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection took place on 1 and 2 May 2018 and was unannounced.

During our last comprehensive inspection in February 2017, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's care records did not evidence that best interest decisions were carried out in line with the Mental Capacity Act (2005). People were not given their medicines in a safe manner and errors had occurred. People were also not supported to have food that was nutritious or appetising or in accordance with their preferences. We found that systems to monitor the quality of the service were not sufficiently robust to ensure issues were identified. We issued the provider with three requirement notices and we imposed a positive condition on their registration.

Following the last inspection, we asked the provider to complete an action plan. This was to show what they would do and by when, to improve the key questions of safe, effective, caring, responsive and well-led to at least a rating of good.

Firlawn Nursing Home 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.

Firlawn Nursing Home is registered to accommodate 40 people across two separate buildings (The House and The Manor), each of which have separate adapted facilities. The Manor specialises in providing care to people living with dementia. At time of the inspection 27 people were living at the service, of which 22 people lived in The House and five in The Manor.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they didn't always feel safe living at Firlawn Nursing Home. They reported that some staff talked to them in a rude manner and of being handled "rough". From our observations people's care was task orientated and did not reflect people as individuals.

We received mixed feedback about the caring approach from staff. People in The Manor appeared to have more positive interactions with staff, than people living in The House.

People's call bells were not responded to in a timely way. We observed call bells ringing for up to 10 minutes, without staff responding. The service had no means of monitoring call bell response times.

People told us of incidents where their calls during the night had been ignored and their call bells disconnected. One person described it as "calling from a personal hell". There was a culture within the home that it was acceptable to leave call bells unanswered.

There was not sufficient numbers of trained staff to meet people's needs. There were people in The House who needed two care staff to support them in the morning. This meant when other people needed support, no staff were available. We observed people were still getting up at 11am.

People were supported to bed at the time that suited the staff team. Day staff told us they supported people to bed as the night staff did not want to, unless people were willing to wait until midnight. This meant some people were in bed from around 7pm until 10.30am the next morning.

People were not always protected against risks and action had not always been taken to prevent the potential of harm. During the second day of our inspection we heard a person calling for help. The person was falling out of bed. There was no staff available to respond. The inspector had to go and find staff to help the person. On checking this person's care plan, the nursing staff did not follow the manual handling care plan, which could have prevented this incident occurring.

Staff had not received training necessary to provide them with the skills and knowledge to fulfil their role. This was evident during our inspection as we observed people were not treated with dignity and respect. We saw large gaps in the training staff had received around dignity and respect. Staff had not received regular supervisions and appraisals.

People's choice and independence were not encouraged. People told us that staff did not consistently ask for their permission before providing care and support.

Consent was not always sought in line with the Mental Capacity Act (2005). It was not clear from people's care records if the person had mental capacity to consent to their care and treatment, or not. We found one person who lacked capacity to consent, did not have a Deprivation of liberty safeguard in place.

People and relatives told us the quality of the food was poor and there was a limited choice. We observed food left on trays while staff were supporting some people in their rooms, which meant the food was cold by the time it was delivered.

People had care plans in place; however we found the information in the plans was not always person centred and was variable in detail. Terminology used in the care plans was not always appropriate and focused on task based care rather than wellbeing.

People and their relatives told us they had raised their concerns with management. Although they felt the registered manager had listened, they did not feel the issues were resolved.

Quality assurance systems were in place and internal audits had been completed, however these were not robust enough to identify any shortfalls. For example, the registered manager did not have an oversight of issues within the service such as falls.

The overall rating for this service is '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.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, of which four breaches were repeated from the last inspection.

We issued the provider with a Notice of Decision, imposing conditions on their registration for two of the breaches: 1. The Registered Provider must not admit any new service users without the prior written agreement of the Care Quality Commission. 2. The registered person must undertake monthly audits of service user care plans, risk assessments and the associated monitoring of these risks, management of medicines, Mental Capacity Act 2005 capacity assessments and best interest decision making and staffing requirements. The registered person must send to the Care Quality Commission a report of the result of the audits and any actions taken or to be taken as a result of those audits by no later than 5pm on the last day of each calendar month.

We issued a requirement notice for six breaches, stating they must take action. We shared our concerns with the local authority safeguarding and commissioning teams. The provider had sent us an action plan with timeframes on what action they were taking to meet the legal requirements.

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

This service was not safe.

There was not sufficient numbers of trained staff to meet people's needs and keep them safe.

Risks to people's health and safety had been identified, however not all practicable steps had been taken to minimise these risks.

Some areas of the home were not clean and staff did not always follow infection control policies.

People's medicines were not always safely managed.

The service did not follow safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not have the right skills and knowledge to enable them to meet people's needs.

Staff were not always appropriately supervised.

The service did not always follow the principles of the Mental Capacity Act 2005.

People were able to access a range of services to meet their healthcare needs.

Is the service caring?

Inadequate

The service was not caring.

People's choice and independence were not promoted.

People were not always treated with dignity and respect.

Care was task orientated and not person centred.

Is the service responsive?

Requires Improvement

The service was not responsive.

Not all staff had a clear understanding of people's health conditions.

Staff were not responsive to people's needs.

Spoken and written terminology was not always person centred.

Is the service well-led?

Inadequate

The service was not well led.

There was not a management overview of the care people received.

Quality assurance systems and audits did not identify shortfalls in the service.

Staff told us the registered manager was approachable and they felt supported in their role.

Firlawn Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 1 and 2 May 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 personal experience of using or caring for someone who uses this type of service. A medicines inspector joined the inspection team on the second day of the inspection.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with 11 people who use the service and seven of their relatives and friends about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included six care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We talked to the registered manager, deputy manager, owners, consultant, domestic staff, kitchen staff, activities co-coordinator, three care staff and a registered nurse. We received feedback from one health care professional.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection in February 2017 we identified that the service was not meeting Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because people were not given their medicines in a safe manner and errors had occurred. Staff had not consistently signed the medicine administration record to show that medicines or topical creams had been given as prescribed. Protocols were not in place in relation to "as required medicines". Systems to ensure sufficient medicines were available were not effective and medicines were not always stored securely or in line with storage requirements.

During this inspection we found improvements had been made, however there were still areas of concern. We reviewed 15 medicines administration records (MARs), which showed that medicines were given as prescribed. Medicines that were prescribed to be given as a variable dose such as 'one or two tablets' were not always recorded to show the actual quantity administered. This meant that staff might not know when people had been administered the maximum dose, putting people at risk of overdosing.

Medicines that needed to be administered at a specific time were not always given at the correct time, for example for Parkinson's disease. A person told us about the impact this had on their health. They said "Some staff give them [medicines] on time, but they can be 45 minutes late. Then I have increased spasticity, I get stomach spasms and it affects my ability to function in every way, so my care needs increase, it's all avoidable". We raised this with a nurse on duty, who said, "We get to it when we can." The nurse did not recognise the impact and importance of people receiving their time specific medicines as prescribed. Another person said "I've had trouble getting hold of my prescriptions. Twice I was told my tablets had gone to [another place] and I missed my tablets."

We found medicines were not managed safely. We observed one person who was on a Peg feed (a tube passed into the stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate) had their medicines left in their room by the nurse. Three pots of medicines were on the table. The nurse told us they had left these as they needed time to dissolve and then they would go back and put them in the peg. We also observed that up to four people's medicines were left unattended on top of the medicines trolley. We remained with the trolley and waited for the nurse to return and asked that this immediately be made safe. This was not a safe practice to leave medicines unattended.

We saw evidence of meetings held in response to staff's errors around medicines. One staff member had received a meeting in April 2018 around failure to ensure monthly medicines had been ordered. We saw that medicines incidents and errors were reported and investigated. An internal medicines audit had been completed but there was not always an action plan to show how the issues raised would be managed. This meant that although the service was aware of issues with medicines management and administration, action was not taken to improve safety and practice.

We received mixed feedback from people living in the nursing unit (The House) about their safety. Five people told us they didn't always feel safe and raised concerns about staff attitude and behaviours. Their

comments included, "I feel safe generally, but some of the staff make me feel anxious, because they're rough in the way they handle me and speak to me. I've been pushed on to my bed. It hasn't happened lately, but those people [staff] still work here, there are more than two to three of them." Also, "I get on with some of the girls, but some of them are rude and unkind. One said to me 'don't bother ringing because I'm not coming'. I've had my arms pulled about and hurt." And, "They [staff] often say 'what do you want now?' in an irritated voice."

Two relatives told us they had been aware of concerns. They said, "We've been aware of some staff being unkind and not giving the help needed, others are lovely" and, "Some of the staff were very uncaring and would say 'what do you want?'

People and relatives told us they had raised their concerns with management. Although they felt the registered manager had listened, they did not feel the issues were resolved. Comments included, "You can speak to [registered manager], she listens but nothing really changes." Also, "I go to [registered manager] with any issues and she listens but things aren't always resolved" and, "I spoke to [registered manager], she dealt with it and I think they were reprimanded, but there are repercussions. They don't bother to answer your bell and they find ways by not doing what you ask." Following our inspection we shared our concerns with the local safeguarding team.

Three people in the nursing unit told us they felt safe, Their comments included, "I feel safe, and most of the staff are okay, I get on with most of them" and, "I feel safe because there are a lot of people around and I'm not alone." Staffing levels were higher in The Manor to the ratio of people living there, which meant people felt safer as staff were visible and available. A person said, "I feel safe because in the day time the staff are around all the time and at night you can call on them if you need them, and they call in to see that you're alright."

We found staffing levels in The House were not sufficient to meet people's needs. Two care staff were deployed in The Manor and four care staff and one nurse in the main home "The House". Three staff were on duty at night. Following a recent quality assurance visit from the Local Authority, who commission services at the home, an extra member of staff was now in place in the dining room and lounge area to support with mealtimes and activities. The registered manager said "We have never got enough staff in care, its better with the fifth member." The home had struggled to recruit nurses and now only provided nursing care in one building. The registered manager told us "There is a nurse shortage on nights." The registered manager used a dependency tool to calculate the number of staff needed. However, we found this wasn't always correct and a true reflection of people's current needs. For example one person's dependency tool stated they were a medium risk and needed the support of one staff member. However, their care plan stated that at times they needed two staff to support them but the dependency tool had not allowed for this.

We observed call bells were not responded to in a timely way and people told us they had to wait a long time before staff responded. They said, "They [staff] are very slow to answer. When you want the toilet they sometimes don't come soon enough and that's very upsetting, the mornings are the worst", "I fell over and managed to crawl along to my bell. I thought 'oh good now they'll be here in about half an hour'", "There aren't enough staff, especially since the other unit opened. I see others waiting a long time for help" and "They [staff] often take 20 minutes to half an hour to come." We observed one person's call bell had been ringing for 10 minutes. The inspector went to ask the person if they needed anything. They told us they had been on the commode for over 10 minutes and had been waiting for staff for support. The inspector had to go and find a member of staff, who were busy supporting other people.

There was no monitoring or auditing of the call bells so the management were not able to see how long

people waited for staff support. The registered manager told us, "The length of call bells are not monitored, we ask staff to answer them in a timely manner and nurses to be aware." We did not observe call bells being responded to in a timely manner.

We found people's call bells were not always in reach. On the second day of our inspection we heard a person calling out 'help me'. The inspector went to the person's room to find the person was falling out of bed. The inspector pressed the call button for help, which the person responded to "Don't know why you did that. They [staff] won't come."

Staff told us they felt under pressure due to staff shortages. Their comments included, "We are short staffed for cleaners at the moment. Not had a proper housekeeper since December 2016. When The Manor was shut it wasn't too bad." Also, "We could always use more staff, can depend on which staff are on duty, some are better at managing their time and organising their work. I think our workload is very high at the moment in terms of people's dependency. We understand staffing costs money but we have a duty. We have raised it about staffing higher up the chain."

Safe recruitment processes were not always followed. We found that not all of the staff files we checked had identification photos in place or health declarations. The provider's policy on selection and recruitment stated that photo and ID for evidence and health declaration of medical fitness should be in place in the staff recruitment files.

One staff member had part of an employee reference missing. The files were disorganised which made it hard to find information amongst the loose papers. One staff members file could not be located, so we were not able to ensure the appropriate checks had been done. One staff member had previously been on a period of suspension for their attitude to people and staff. This staff member then left, but then returned to ask for their job back in 2017. They were initially told no, but we were informed due to the difficulty recruiting staff, they were allowed to return. We saw there was no record of regular supervisions or monitoring following their return. The registered manager told us they normally would have done this but had been too busy.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

People were not always protected against risks. We found risks assessments, for example the risk of falls, were a 'tick box exercise', providing a score to identify if the person was at a small, moderate or high risk of falls. There was no guidance for staff on what to do to minimise the risk of falls. This was also the case where people had been identified to be at high risk of malnutrition or pressure areas. Some care plans had no information about what action to take and others very limited information. This meant action had not always been taken to prevent the potential of harm being caused.

Preventative measures to reduce risks were not being used appropriate. One person had experienced nine falls over a one-month period. The records of one fall stated the person was found on the bathroom floor. An alert mat was in place, but this had not alerted staff to the fall, as they had failed to install the mat and ensure it was working. Another person had heard this person calling for help, but could not help them as staff had left her call bell out of reach. This person was put at risk by staff. There was no further action documented in response to this incident. It had not been investigated appropriately and CQC had not been informed of this incident. This person had during another fall hit their head and had to be taken to hospital in light of the injury. Again, no notification made to CQC.

Despite being moved to a ground floor room in the other building to minimise their falls, we saw the person had continued to fall. We saw that on one fall in the new building they had not had a sensor mat in place, despite having it in the other building. We were informed there had been "a mix up", and a staff member said people with dementia could not have an alert mat. This person had been put at further risk by not having this mat in place and subsequently fallen. If this mat had been in place it would have alerted staff to support this person and the fall may have been avoided. This had not been investigated properly. We asked the registered manager to investigate this incident, which they started during our inspection by informing the family and speaking to staff. No notifications had been made to CQC or the local authority safeguarding team about this incident.

A body map for this person had been put in place in May 2108 recording that the person had seven bruises. We raised this with the registered manager who was unaware of this or how the person had obtained these bruises. We asked the registered manager to investigate this without delay.

After people had fallen there were no continuing observations documented to check for later injuries or bruises that may present. Where people did raise concerns that they had a bruise there was no action taken or investigations made. For example, one person had raised concerns that they found being hoisted was painful. There was no record of any actions taken around this to ensure staff were safely hoisting the person in the correct way.

We saw that staff did not always follow people's moving and handling care plans. For example, where one person was observed falling out of bed. The person's moving and handling care plan stated "[Person] has poor sitting balance so needs to sit in a supportive chair with cushions if needed. [Person] has bed rails on her bed to prevent her from falling out of bed as she tends to lean to one side." A staff member told us a nurse had sat the person up to have their breakfast and had left them in that position. There were no bed rails in place. The daily record stated "[Person] was found hanging out of bed this morning. No injuries. Call bell not at hand. [Relative] informed. He said mum always had the side up at home. We will do a bed rail risk assessment." This meant the service did not take all practicable steps to minimise the risk to people's safety.

We saw that infection control was not always managed appropriately. For example, on several occasions staff were seen in the corridors or entering or exiting peoples' rooms with their gloves on. This meant the risk of spreading infection was increased. We saw a sign in the corridor stated gloves were to be kept in the sluice room; however, four packs of gloves were piled up on a table in corridor under this sign. We observed that there were strong smells in both of the sluice rooms and the sinks in these did not look clean and were stained. The bathroom on the first floor was not accessible to people should they need to use it. We saw two large hoists were stored in this bathroom and blocked the use of the toilet.

This remained a breach of Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Safe care and Treatment. We issued the provider with a Notice of Decision, imposing conditions on their registration.

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection in February 2017 we identified that the service was not meeting Regulation 11 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because people's care records did not evidence that best interest decisions were carried out in line with the Mental Capacity Act (2005). Following that inspection, the provider sent us an action plan, stating what action they were taking to meet the legal requirement.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found consent to care was not always sought in line with the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People told us that staff did not consistently ask for their permission before providing care and support. One person said, "The staff don't always ask permission or explain what they're going to do. It depends who, some do." We observed that people were not always included in decision making. We saw one person had a document in place to consent to care and treatment in the home but this was signed by the registered manager. Only people who had legal powers to do so, can give consent on another person's behalf.

It was hard to establish from the information in people's care plans if some people lacked capacity or not regarding specific decisions. There was a clear lack of understanding from some staff and the management team around mental capacity and completing assessments. For example, one person's care plan stated their mental cognition was "muddled". It then stated he could make daily decisions and decisions around his health and welfare. However, later it stated he had fluctuating capacity. An assessment had been done regarding a sensor mat being in place. This had been done the day of our inspection as had not previously been completed even though the sensor mat had already been used. This had been a restriction to the person without the appropriate consent. The person needed information presented in coloured large print to aid him making decisions, however it had not been presented in line with this. We spoke to the registered manager about this person being free to leave the building and they said he could not leave without staff supervision. There was no DoLS in place for this person which meant they were being unlawfully detained.

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

People and their relatives had mixed views about the skills and caring nature of staff. Comments included, "The night nurses are really bad, they do one to two nights and they don't know people or what's going on." One person said, "I'm prone to choking so I have soft food. I don't like it, but choking isn't pleasant. When it happens staff pat me on the back. I go down to lunch but I eat my other meals here on my own, I'm not sure what would happen if I choked as they don't come quickly." Positive comments included, "The staff know me, they do everything I can't do for myself, they've definitely got all the right skills." Also, "The manager and some of the nursing staff have years of experience, you know the skills are here".

Staff did not always have the training they needed to meet people's needs and ensure their safety. We checked the training matrix and identified gaps where staff had not received training. For example, training in dignity and respect, equality and diversity, dementia, first aid, mental capacity and challenging behaviour. We observed during our inspection that some staff did not have a good understanding of treating people with dignity and respect.

Staff had not been supported to receive regular supervisions or appraisals with a line manager. One staff had not received an annual appraisal since 2013. The registered manager told us, "We talk all the time but it's not documented." Another staff member had not received supervisions since 2016. One staff member's supervision record had no date recorded on it, so it was not clear how recently this had taken place. The provider's supervision policy stated they should take place in three monthly intervals and that full records of this should be maintained. This policy had not been followed. The registered manager told us "Appraisals have not been happening, it's been too busy. I do supervisions when I can; some staff have had ten this year and others not so many."

This was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

At our last inspection we found a breach of Regulation 14 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because people were not supported to have food that was nutritious or appetising or in accordance with their preferences. During this inspection we found people were still not satisfied with the choice and quality of the food they received.

Only two people said the food was "very good" and "excellent". All other people we spoke with in both units said they didn't like the food much. Comments included, "The food is so-so, it's a shame the cook left last year, sometimes it's edible but the bread in the evening is very thick and I can't manage it." As well as, "The food is not really very good and everything is cold, even the tea." And, "The food is disgusting, and when I came back late from hospital once there was no food available. That's got better because I complained, and some staff will look in the kitchen if you're hungry in the evening, and see what they can find."

Relatives and visitors' feedback about the food included, "They stopped doing hot meals at night and gave [family member] things like salad, which they couldn't eat. That's been sorted out." Also, "The food is not very good, we did raise this, and it slightly improved".

Some people's hot meals were left to go cold before they received them. Staff were responsible for collecting meals including breakfast from the kitchen. We saw that meals were left on trays, while staff were supporting people to eat, which meant by the time staff were able to deliver the meal to people in their rooms, the meal was cold. This was an issue raised in a staff meeting, stating that some breakfasts had to be sent back to the kitchen because it was cold. We observed during our inspection that some people waited for a significant time before receiving their meal. We also saw that people were not asked what drink they wanted, for example tea or coffee. Staff did not offer people choices, but gave them what they thought

people always had.

People chose their main meal for the next day, from two meal options (meat or vegetarian). This meant that people might have changed their mind on the day. This was also the case for people living with dementia. They would benefit more from being giving a visual choice on the day, to assist them in choosing a meal. The chef told us if people changed their minds on the day, they would be offered an alternative.

This remained a breach of Regulation 14 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

We received mixed feedback about how the service responded to people's health needs. Comments included, "I told them about this rash (shingles). I knew what it was; their emergency response isn't very good. They didn't do anything until it got much worse and then they called the doctor who agreed it was what I'd said at the beginning. I could have got treatment a lot earlier, it got very painful." Another person said, "I fell over last year and hit my head. The next day I was at the dentist (specialist dental service) and they were worried about it and dealt with it. I had to have a scan." Also, and "The night nurses are really bad, they do 1-2 nights and they don't know people or what's going on".

Some people said staff were competent and knew how to look after them. They said, "The staff are mostly competent and quite observant sometimes." People told us that they had access to chiropodist, optician and dental services. Some people had been able to maintain access to their regular dentist or optician as family took them there.

Most people said their rooms were small and they hadn't been able to bring much from home to personalise them. They said, "This room is very small, the best thing about this place is the view from the window, but there wasn't the space to bring much with me". "The room is very small, but a bigger one would cost more and as I can't get about, I don't see the point of paying extra" and "Some of the rooms are diabolical; I've got one of the best here which opens on to the patio."

We found the environment was not always suitable for people living with dementia or with poor vision. There were no signage or colour coded door frames to orientate people. There were no clocks in communal areas to orientate people to time. The orientation board in the dementia unit was very small and contained a lot of information which could be confusing for people.

Inadequate

Is the service caring?

Our findings

People were not always treated with kindness and compassion in their day-to-day care. We observed some staff going into people's bedrooms after they had called for help, saying "What do you want?" People told us some staff made them feel uncomfortable.

Some staff did not show concern for people's wellbeing in a caring and meaningful way, and did not respond to their needs quickly. One person showed us a note they had written, describing their experience of the care received at Firlawn Nursing Home. They described being left waiting, sometimes without access to a bell, as "hurt upon hurt" and "calling from a personal hell."

Staff did not always treat people with dignity and respect and we observed some undignified practices. For example, we observed one person had been left on the commode for ten minutes without staff returning to support them. This person had rung their call bell, but no staff had been available to answer. We went to check on this person and they were on the commode and said to us in a distressed voice, "I have been waiting and waiting for staff." We then personally went to locate a member of staff to provide support to this person. Other comments from people included, "They [staff] don't always realise that this [room] is my home and they don't always respect the way I like to have it organised." Also, "A man [member of staff] came into my room in the dark in the night and said 'what do you want?' I hadn't called and I'd never seen him before. It was really unbelievable."

At times we observed staff entering people's rooms without being invited in. Some staff then spoke in an inappropriate manner to the person. One staff member entered someone's room calling for another member of staff and only acknowledged the person whose room it was as an afterthought. We saw one person who using their commode consistently was left with their bedroom door open during this time. This was despite staff walking past and observing this, and the nurse station being directly opposite. On one occasion, we asked a staff member to please close the door to give the person some privacy. The staff member told us, "They are independent". This was said as justification for why the person did not need their dignity maintained.

People we spoke with confided that staff did not always respond to their needs in an appropriate manner. We were made aware of occasions where staff had been rude to people's requests telling them to stop asking until the staff were ready to help them. There were reports of staff being "rough" with people when they supported them as well as times where people were refused help because staff were too busy. Some people told us they were concerned about raising concerns about staff, as they were worried about the repercussions it would have on them. One person said, "I once spoke to one of the staff about the harsh way they treated someone in a wheelchair and that person [staff member] hasn't looked at or spoken to me since. It was a few years ago, not a smile or acknowledgement of any kind in all that time." Another person told us if they raised concerns, that certain staff would disconnect their call bell, so they could not call for help.

People raised various concerns about the way night staff had treated them. One person told us they did not

have a choice in when they went to bed or when they got up. They said, "I don't really get much choice about what time I get up or go to bed because it depends when they [staff] and the hoist are available." Another person commented, "I get some choice about when to go to bed, but the girls like to take me up before the night staff come and I'm happy to go along with it." A staff member told us this was because the night staff would not support people to bed when they got on shift and then had to wait until midnight before night staff would support them. This meant day staff supported people to bed early, leaving some people in bed from around 6–6.30pm until 10.30am the next morning. We were also told of a person who did not want their cup of tea at 6am in the morning, requesting a later time after 7am. A staff member raised this with a night staff member, who said "Well, she [person] won't get one then." We saw that concerns were raised during a staff meeting in April 2018 regarding ensuring that people were treated fairly and given choice regarding getting up and when they would like to have their breakfast. This remained an issue during our inspection.

This was a breach of Regulation 10 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

People also told us their preferences were not always respected. For example, to have a female or male carer support them, or follow their religious beliefs. One person said, "I needed cleaning down below and I didn't know the male carer, who was new, so I was reluctant as I didn't know his experience. I asked for someone else, but no-one came for hours and they [staff] said I shouldn't have refused to have the man." Another person commented, "Some of the male carers' behaviour isn't appropriate or dignified." A person told us, "I can't get to church and I'd really like to do that, I enjoy Holy Communion but it's only once a month and it's important to me to attend church."

People were not encouraged to be as independent as possible. We observed a person making themselves a drink from the tea trolley. A staff member stopped the person, stating "You [person] don't need to as I'm here to do it for you." This person was very capable of making their own drink. They also said, "I've been told I can't go out on my own. I'm not allowed to walk into the village in case I fall over and they say it would reflect badly on the home. I walk around the grounds and the field."

This was a breach of Regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Visitors told us there were no restrictions on visiting times and they felt welcomed. One relative said "We're always welcomed and offered tea and cake."
People in The Manor appeared to have more positive interactions with staff, than people living in The House. The positive comments included, "The staff are kind and helpful and I'm happy with them", "I get on well with all the staff, we have a chat and a joke." Also, "Some of the staff are really kind." And, "Some of the girls are lovely and they like to go through my earrings with me helping me choose what to wear."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2017, the provider was not meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. This was because care charts did not consistently monitor aspects of a person's care such as hydration, continence and the management of healthy skin.

For people at risk of malnutrition or dehydration a monitoring chart was in place to record their food or fluid intake. These were not always completed correctly. For example, one person declined their meals on a regular basis but there was nothing recorded to state if alternatives had been offered to this person, or the action taken. This person's fluid chart did not always have the amount recorded, so it showed the person had a cup of tea but it was unknown if they had drank this or not. Their recommended intake target was 1560mls. However, this person was consistently drinking less than this, on some days recordings showed 650mls with no actions taken. Another person had not been offered a drink on one day between 9am and 8pm. One person on a repositioning chart was meant to be supported to change position every two to three hours but we observed during our inspection they were left for a period of four hours. This person was at risk of developing a pressure ulcer and was being put at risk by not receiving the correct support.

We found some of the charts used to monitor people's fluid intake when they had been identified as being at risk of dehydration were not fully completed. For example, charts we looked at stated for their fluid output for that day 'pad wet' or 'wet' and for their fluid intake; '200mls' had been written. Fluid charts had also not been totalled at the end of each shift to ensure people's fluid intake had been monitored. This was despite it being an action the service had planned to implement following the last inspection. This did not show people's fluid intake was being consistently monitored to identify the need to seek medical advice or other supportive intervention in a timely manner. We also found that staff pre-recorded on the fluid charts, before the person had taken the fluids. For example, we checked a fluid chart at 12.55. Staff had already recorded at the 13.00 entry, the fluid type as cranberry and initialled the entry. There was no amount recorded, which meant if staff went back later to record the amount, that the entry might not be a true reflection of what the person had drunk.

These findings were a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This had been the third consecutive time that the provider had not met this legal requirement.

People had care plans in place. Details were recorded around things that were important to a person, how they preferred to communicate and about their daily routine. However, we found the information in care plans to be variable. Terminology used in the care plans was not always appropriate and focused on task based care rather than wellbeing. For example, we saw statements including "all meals and fluids taken", "bath given, hair washed" and "staff to walk [person] as much as possible." People's goals and aspirations were recorded, but this focused more on what was happening, rather than identifying new goals or how to achieve them. For example, one person's care plan recorded the person wanted to improve their mobility but not how they could be supported to do this.

There was evidence that care reviews were taking place. One person's six monthly care review looked at aspects of the person's care, goals and aspirations. This had then been signed by the person.

Handover took place at the start of each new shift to ensure information was shared and staff coming on shift had updated information about people. We had received feedback from a health care professional that this was not always the case, especially when agency staff were on duty. They said the nurse in charge was not always informed about any changes in people's health or behaviour.

People told us they had opportunities to attend residents' meetings. The residents' meetings were arranged by the activities co-ordinator and chaired by the registered manager with other heads of departments present. People said that they had attended and some felt they were positive and led to changes from their suggestions. Comments included, "I asked if we could have poppadums with curry and we do now" and, "I suggested that we have cake forks when we have birthday cakes, so that was organised". Others didn't feel listened to and their comments included, "[Registered manager] tells us what we think and want, we're not asked and of course a lot of people can't speak out." Also, "I have been in the past, but nothing changes as a result."

People could take part in activities if they wished to do so; however, we received mixed feedback about the quality and appropriateness of the activities. Positive comments included, "I love the activities, [activities co-ordinator] is marvellous in what she does, I love the singers and like to join in if we have the words." Also, "They do try with the activities and do crafts such as Easter eggs. I go to the craft sessions." Negative comments included, "I don't go to the activities, I'm not a group person and the things they do are babyish", "I stay in my room and watch television, intelligent conversation is really lacking here." As well as, "Some of the activities are appalling; I don't like the noise from live music as the amplifiers are just too powerful for the room". Relatives also felt that people didn't have sufficient social stimulation. They said, "There aren't enough activities, my [family member] never had 1:1 visits, although it was recommended twice a week" and "My [family member] doesn't go down as they don't like it and poor vision limits what [family member] can do, they've never had a 1:1 visit in their room."

Activities included crafts, quizzes, a monthly visit from entertainers such as dancers or musicians, a monthly mobile library visit, a weekly shop, and themed seasonal activities. The local Brownie group came in and a pre-school group visited at Christmas. There were plans to develop this further. Holy Communion was held once a month. Information about people's interests was gathered from their Life Story profile and they could make suggestions at the residents' meetings. There were also two big outings, one at Christmas and one in the summer. The activities co-ordinator told us people who chose to stay in their rooms, had one-to-one visits, which could be for a chat or a hand massage. However we could not find any evidence that these one-to-one visits were monitored, to ensure people who spent large amounts of time in their bedroom, was not at risk of social isolation.

We observed three people participating in a buttonhole activity with staff on the morning of the first day of inspection. Another person was having a one to one with a staff member and the fifth person had visitors. We were told the activity staff oversee the activities in both buildings but staff have to do the activities in The Manor. During our inspection the weather was lovely, but people were not observed using the outside space or being encouraged by staff to do so. One staff member told us, "There are lots of things for people to do but they don't necessarily want to engage. They enjoy reminiscing and informal chats. The other staff in the lounge helps to focus the activity person to do what she's doing." We saw in The Manor staff had time to sit and chat with people but there were only currently four people in the building. However, there were no planned activities taking place, it was more just checking on people who were sat around the lounge.

We saw that the complaints procedure that was given to people and displayed in the home did not give correct information. It stated that "CQC will acknowledge the complaint in writing and inform the complainant of how it is to be investigated." This is not correct as CQC does not manage or investigate individual complaints, but instead uses information for monitoring purposes. We raised this with the management to address. We saw one complaint made in 2017 from a person living at the home stated they were told by staff to not use their call bell as the staff had a lot to do that day. This had not been properly investigated and similar complaints were raised at this inspection.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014.

People and their relatives were given support when making decisions about their preferences for end of life care. We saw people's end of life wishes had been recorded in their care records, however we found this was not always consistently recorded. Some care records lacked detail around people's preferences for end of life care. The registered manager told us that some people did not wish to discuss this; however, there was no evidence to suggest the registered manager revisited the discussion with people at another time.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2017, the provider was not meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. This was because systems to monitor the quality of the service were not sufficiently robust to ensure issues were identified. As a result of a history of non-compliance with regulations, a condition was issued on the provider's registration. This meant the provider was required to send the Care Quality Commission monthly reports regarding people's care plans, risk assessments and the associated monitoring of these risks. As well as, management of medicines, Mental Capacity Act 2005 capacity assessments and best interest decision making and staffing requirements.

During this inspection we found the service continued to be in breach of regulations and the provider had stopped sending us monthly reports. The last report we received was January 2018. This meant the provider had not met the condition on their registration.

The registered manager had mostly notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. However, we found the registered manager had not reported an incident which was notifiable to CQC, where a person had been sent to hospital for a scan with a potential serious injury.

The registered manager had not been able to manage their workload effectively or retain adequate leadership and oversight of the service. There was evidence that the registered manager had felt under a lot of pressure and told us they had been a "glorified administrator". They said the owners were now involved more and visiting the home and the consultant had been supportive commenting "He listens." The provider had brought in the consultant to work alongside management to identify shortfalls and make improvements where necessary. The registered manager was also due to start having some administrative support, which would allow them time for their managerial duties instead. There was also a deputy manager in post, who worked alongside the registered manager.

There was not always effective quality monitoring of the service by either the registered manager or the provider. Audit tools were in place to monitor falls in the home as there had been a significant number for some people; however there was no evidence to show that the audits were analysed to identify any patterns or trends. Information could be taken from accident reports, but was considered separately and not as an oversight to analyse patterns and implement wider change. Staff completed observation checks on people at night, but there was nothing documented to show these happened and the frequency. Care plan audits identified issues, for example where information was missing, but there was no evidence of an action plan or follow up to resolve the issues.

There was no management overview of the quality of care people received. This included the staff culture, task orientated routines and the lack of dignity and respect some people experienced. Staff were not appropriately trained or supervised. One member of staff, who had been recruited without a clear rationale for doing so, was not formally monitored.

Staff felt there had been improvements since the last inspection but felt the work load pressures had been a challenge. One staff member told us, "We are in a position where we have room to improve. We have done a lot improvement on care plans and gaps on MAR's. Room charts are not perfect but they have improved. The last four months have been really hard for the management in terms of the workload coming at us from the owners and consultant."

Staff told us they felt supported to an extent by the registered manager with one staff member saying, "I feel supported by the manager, I have raised concerns and if they are able to deal with it they will. Concerns raised on a bigger scale beyond the registered manager's control I'm not so sure about."

People and their relatives had the opportunity to give feedback on the service they received. We reviewed the comments from the 2017 survey which had mixed positive and negative responses. Comments from relatives raised concerns around not being given good information on the complaints procedure, no urgency in people being given their food when eating in their room which meant it was cold when people received their meal. These were issues that we identified as still being present during the inspection. This meant that the registered manager was aware of concerns, but appropriate action had not been taken as a result of the survey.

We saw that the service had displayed their rating from the last inspection in the reception. There was also a folder which contained the full report for people and visitors to read. However, the previous operations director details were also in this folder and needed updating. We raised this with the registered manager who said the information would be updated.

Most people and their relatives knew the registered manager by name and said they were comfortable with raising any concerns. Comments included, "If I needed to, I'd just talk to and it's not a problem to tell [registered manager]." Also, "I had a private chat about my worries with [registered manager] and I feel better that she'll sort it out for me." And, "[Registered manager] makes a point of coming out to see you in the lounge and asks if everything is alright, and you feel that's not just something to say but because she really wants to know."

We observed there were no clear professional boundaries between the registered manager and some staff. A person also told us "The manager isn't strict enough; it's my observation that she's too friendly with the staff and it's not good for discipline." This meant that poor practices identified during the inspection, had not been addressed with specific staff members.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014. We issued the provider with a Notice of Decision, imposing conditions on their registration.

People told us they wanted to see improvements within the service. They said, "If the food could be better that would be a good change", "I'd just like to see more staff on duty", "I'd like to get to church on Sundays" and "I'd like to feel confident that people won't push and pull me or be rude to me."

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 9 HSCA RA Regulations 2014 Person-centred care Care was not reflective of people's individual needs. People were not involved in decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. People told us that some staff were rude and handled them rough.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always sought in line with the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not receive nutrition and hydration according to their choices. People were not satisfied with the quality of the food on offer.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

	The registered manager did not operate an effective system for identifying, receiving, recording, handling and responding to complaints by service users.
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform.

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 Medicines were not always managed safely. People who were prescribed time specific medicines, did not always receive it as prescribed. Not all practicable steps had been taken to minimise risk to people's health and safety. There was not sufficient staff to meet people's needs and keep them safe. Recruitment practices were not safe. Staff had not always followed infection control policies and some areas of the home was not clean.

The enforcement action we took:

Notice of decision imposing a condition on the provider. The registered person must undertake monthly audits of service user care plans, risk assessments and the associated monitoring of these risks, management of medicines, Mental Capacity Act 2005 capacity assessments and best interest decision making and staffing requirements. The registered person must send to the Care Quality Commission a report of the result of the audits and any actions taken or to be taken as a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had not taken the action they said they would to meet legal regulations since our last inspection in February 2017. They had also stopped to meet the condition imposed on the provider's registration. There was not robust systems in place to identify shortfalls and monitor the quality of the care people received. Shortfalls we identified at our previous inspection, remained during this inspection. We found three repeated breaches of regulations.

The enforcement action we took:

Notice of decision imposing a condition on the provider. The Registered Provider must not admit any new service users without the prior written agreement of the Care Quality Commission.