The Firs Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 and 29 September 2016 and found that the provider had breached regulation in relation to the safety of people living at the home. The provider had not ensured people's known risks were managed well and had not made sure systems were in place to mitigate risks. Following this inspection the provider sent us an action plan stating what they intended to do to meet the breach of regulation.

We carried out this unannounced focussed inspection on 5 July 2017 to see if the registered provider had followed their plan and to determine if they were now meeting legal requirements. This report only covers our findings in relation to this focussed inspection which looked at whether the service was safe. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Firs Nursing Home on our website at www.cqc.org.uk.

The Firs Nursing Home provides nursing care and accommodation for up to 25 people who are predominantly living with mental health needs. There was a registered manager at the service who was present throughout our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that there had been some improvements made and the provider was no longer in breach of regulation.

People told us they were supported safely by staff. People received safe support when mobilising around the home and when being supported with their medicines.

Improvements had been made in the assessment of people's risks and new systems had been introduced to ensure the risks associated with people's individual needs were now better managed. Although these improvements had been made we found further work was needed to ensure these were carried out consistently and to ensure people were protected from the risk of reoccurring accidents or incidents.

Whilst most medicines practice was safe we found that further improvements were needed in some records and in ensuring information was always available around 'as required' medicines.

There were sufficient staff available to support people. We found that many aspects of safe staff recruitment were in place although further improvements were needed to ensure all checks carried out were robust.

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.

Whilst improvements had been made to the management of risk, further work was needed to ensure this was consistently applied.

Although most medicines had been given safely we noted some improvements was needed in the recordings of medicines and in the management of medicines given on an as required basis.

Some aspects of the recruitment process needed to become more robust.

People were supported by sufficient staff who had a good knowledge of how to safeguard people at the service.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focussed inspection on 5 July 2017. This inspection was carried out to check that improvements to meet the legal requirements had been made. The two inspectors who carried out this inspection inspected the service against one of the five questions we ask about services: is the service safe?

As part of the inspection we reviewed information we held about the home. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We reviewed the information from notifications to help us plan our inspection. We received feedback from local healthwatch who are an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We requested feedback from the commissioners and the local clinical commissioning group.

At the inspection visit we talked to three people who lived at the home, the registered manager, two nurses, one relative and three staff members. We spent time in communal areas observing how care was delivered and 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 talk with us. We sampled records including two medication administration chart, staff rotas, two care plans, risk assessments and maintenance records.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 28 and 29 September 2016 we found that people did not always receive safe care and treatment as the provider had failed to ensure that systems were in place to mitigate risks to people or manage known risks robustly. At this focussed inspection we found that progress had been made to address some of the areas and the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However some areas still required further improvement to ensure they were carried out consistently and became embedded into practice.

People told us they felt safe living at the home and that there were sufficient staff available to support them when they needed it. One person told us that there were, "Enough staff, help anyway possible." The one relative we spoke with told us that their relative was safe living at the home and said, "It's good. I can't find any fault." We observed staff supporting people safely when assisting them to mobilise around the home. We saw that staff provided reassurance and did not rush the person whilst they mobilised to maintain their safety.

At our last inspection we had identified that immediate checks on people's well being had taken place following an accident or incident. However there was no further analysis to determine if measures could be put in place to reduce the risk of a similar incident occurring. At this inspection we saw that work had started on compiling a tool to analyse these incidents but this was not yet complete and people were still at some risk of not being protected from avoidable harm. The registered manager agreed to take action to ensure further analysis of accidents or incidents occurred.

Following our last inspection improvements had been made to the analysis of risk associated with people accessing the community on their own. Detailed assessments had been undertaken with the people living at the home to determine people's support needs when accessing the community. Where risks had been identified we saw that in the most part steps had been put in place to reduce this risk although one care plan did not clearly state the support the person needed. In addition improvements had been made to the systems in place for knowing when people had left the building so staff were now aware of people's whereabouts at all times.

The registered manager had worked with staff and the cook at the home to further improve their knowledge of supporting people to eat safely. The cook had improved their knowledge of how to prepare food safely and understood people's individual dietary requirements. Further measures had been put in place to make sure people were supported safely with their meals such as ensuring staff were always available in the dining room at meal times. Detailed risk assessments and support plans had been introduced around people's requirements of eating safely which also took into account associated risk factors relating to people's health conditons. The systems that had been developed enabled staff to visually identify which people were at higher risk with their eating and drinking. We saw one example where the care plan and risk assessment contained differing information. Whilst there had been no impact on this persons care the registered manager agreed would be rectified.

We saw that improvements had been made to the assessments of people's risks. Risk assessments were reviewed monthly to ensure they continued to be up to date. Improvements that had been planned to the handover of information between staff about changes in people's care had not yet fully been implemented. However the registered manager was taking steps to continue with these improvements. Staff were aware of the risks associated with people's care and described action they took to minimise these risks.

We looked at the processes in place to ensure people were safe in the event of a fire. We were provided with evidence that equipment had been serviced regularly to ensure it was in good working order. Fire drills which involved the people living at the home had taken place in order to practice fire evacuation. The provider had commissioned for an external fire risk assessment to be undertaken to ensure the premises was safe. We saw that some actions that were needed following this assessment had not been completed. Following the inspection the registered manager confirmed that they had checked this and all outstanding actions had been completed. Staff were aware of the procedure for supporting people in the event of a fire. The majority of staff had completed fire safety training and additional training had been booked for those staff who were yet to complete this Where people were at high risk because of associated behaviours, risk assessments and equipment had been put in place and extra checks were undertaken. In addition the registered manager had involved the local fire officers in the assessment and reduction of the risk for these people. We noted that improvements were needed in the providers business emergency plan to ensure consideration had been given to the specific needs of the people using the service.

At our last comprehensive inspection we had deemed medicine management to be safe. We sampled medicine administration at the home to check that this had been maintained. We found that whilst many aspects of medicine administration continued to be safe there were some areas that needed further improvement. For example, we noted that there was not always a record to state why certain medicines hadn't been given and protocols were not always available that stated when people would require their as required medicines. Staff had received training in medicine administration and we saw that the registered manager had carried out checks to ensure staff did this safely. We saw staff offer explanations to people when medicines were administered and gentle encouragement was given where needed.

At our last comprehensive inspection we had judged that staff were safely recruited. At this inspection we checked staff recruitment to ensure this had continued. We found that whilst most checks had ensured staff were recruited safely there was some improvements needed in the validation of references sought from previous employers. The registered manager agreed to address the improvements needed. We saw there continued to be sufficient staff available to support people when they needed it.

At our last inspection in September 2016 we found that staff were knowledgeable about how to safeguard the people living at the home. At this inspection we found that staff continued to be aware of the signs of abuse and appropriate action they would take should they have concerns. The majority of staff had received training in safeguarding and training was planned to provide the remaining staff with this training.