South West Care Homes Limited

The Firs

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of The Firs on 6, 16 and 17 July 2018. The Firs is a 'care home' without nursing. Nursing care, if needed, is provided by the community healthcare team. The Firs also offers temporary respite stays but no-one was staying as respite during this inspection. People in care homes receive accommodation and personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The Firs accommodates up to 27 people in one adapted building. At the time of our inspection there were 16 people living at The Firs.

There was a registered manager at the service. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They were currently not working at the home which was being managed by the deputy operations manager and the operations manager on site. Both had worked for the provider for some time.

The last comprehensive inspection was in September 2016; at that inspection the overall rating for the service was good and we found that people were safe. A recommendation was made that the service sought advice and guidance on developing activities for people living with dementia. At this inspection in July 2018, we found that 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. There were no audits about how people were spending their day. Activities offered by staff and external entertainers, did not ensure each person had their social and leisure needs met.

A focussed inspection was completed in February 2017 to look at safety issues at the service following some concerns about how risk was managed; at that inspection we found the service was safe. In November 2017 we found during a focussed inspection that the service had not submitted statutory notifications to the Care Quality Commission when particular events had occurred. Checks and audits were carried out routinely but these had not always identified issues that were found during the inspection. Care plans did not always fully reflect people's risks and needs when changes occurred. When incidents had happened, plans did not always take into full consideration how to reduce the risks of reoccurrence. During this inspection in July 2018 we found people's care plans were detailed and identified risks, safeguarding issues were identified and shared with the local authority, we received notifications as legally required and audits, other than for activities were good.

This inspection was brought forward because of safeguarding concerns. Prior to our inspection, the service became part of a whole service safeguarding. An individual safeguarding process remains ongoing. 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 registered manager had been part of these discussions. Actions from this process included reviewing and monitoring people's care as part of a whole home safeguarding process. The service has recently completed a number of improvements in response to the concerns raised as part of the safeguarding process. For example, in relation to health concern and documentation. We did not look at the specific concerns relating to the individual's care but inspected to check if other people were at risk. The whole home safeguarding process has now closed with the service making good progress in embedding improvement. We found during this inspection that there were two areas requiring improvement in relation to a lack of consistent provision to meet people's social and leisure needs and there were improvements needed to ensure medicine management was robust to keep people safe.

On the day of the inspection there was a calm and relaxed atmosphere in the home and staff interacted with people in a friendly and respectful way. People were able to choose what they wanted to do and where they wanted to spend their day and enjoyed spending time chatting with the staff who were visible and attentive. Most people were independently mobile and able to move towards staff in the communal areas if they wanted to engage with them. People looked comfortable and happy to spend time in the large lounge/conservatory or dining area or choose to spend time in their rooms.

Staff ensured they had identified those who could not use their call bells easily, and they were checked regularly. People were encouraged and supported to maintain their independence and risk and independence was well balanced in the least restrictive, safe way. Staff engaged with people in ways which reflected people's individual needs and understanding, ensuring people mobilised safely from a discreet distance.

People and relatives said the home was a safe place for them to live. Comments included, "I can leave here and know that my loved one is well looked after. They brought her flowers from the garden and pop in for a chat" and "He is very happy now. I think [the registered manager] is doing a wonderful job here. I am happy with the standard. They are safe, yes."

Staff had received recent training in how to recognise and report abuse. Any safeguarding concerns had been managed well with provider involvement and they had listened to any advice, and the service worked openly with the local authority safeguarding team. Relatives said they would speak with staff if they had any concerns or complaints and issues would be addressed. Staff were vigilant about protecting each person from possible negative interactions with other people living at the home, recognising frustrations and misunderstandings between people due to them living with dementia. They used chatting and distraction techniques as they knew people well, showing patience and understanding. One person, for example, was having a walk with staff around the garden as they were becoming agitated. Staff knew what to chat about to help the person feel calmer.

People were well cared for, and people and relatives were involved in planning and reviewing their care as much as they wanted to be. Staff demonstrated kindness and compassion for people through their conversations and interactions. People's human rights were protected because the management team and staff had an understanding of the Mental Capacity Act 2005 (MCA).

There were regular reviews of people's health, and staff responded promptly to changes in need. For example, care records of people currently living at the home showed many examples of staff identifying changes in need and appropriate and timely referrals to health professionals. For example, one person was having regular appointments with a specialist dentist and another person had regular appointments to check their pacemaker. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

Medicines were generally well managed and they were stored in line with national guidance. Records were completed with no gaps, and there were now regular audits of medication records and administration to help ensure the correct medication stock levels were in place. We made a recommendation to ensure all issues were identified robustly, although the monthly audit would have picked up these issues which were due to take place.

Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. There was a comprehensive training programme covering a wide range of topics. The training matrix showed staff were up to date or booked on training. A comprehensive induction was completed by new staff and supervisions and appraisals were up to date and showed meaningful discussion. The staff team was stable and many care staff had worked at the home for some years as the service was in a rural location.

People's privacy was respected. Staff ensured people kept in touch with family and friends and there was open visiting with people made welcome. All people living at the service had family and friends able to visit.

The management team said they were keen to give people good care and valued their staff team. Staff said they enjoyed working at the home and it was seen as important in the local area as it was so rural and a small community. Staff had clearly adopted the same ethos and enthusiasm as the management team and this showed in the way they cared for people in individualised ways following the company ethos of promoting choice.

Observations of meal times showed these to be a positive experience, with most people choosing to join each other in the dining room. People were supported to eat a meal of their choice where they chose to eat it at times of the day to suit their appetite. People were supported discreetly to be as independent as possible, using adapted crockery, having finger food or snacks when they most had an appetite.

The premises were clean and smelt fresh. The building was an older style premises with a modern extension but had been well maintained and there was an ongoing maintenance programme. The staff and relatives said there had been a lot of work recently to improve the garden areas with new garden furniture and flowers. The décor was interesting for people living with dementia and promoted their independence with accessible signage.

Apart from relating to activities and improvements needed in the medicines audit, there were effective quality assurance processes in place to monitor care and plan on-going improvements overseen by regular provider audits and topical surveys. Recommendations from a recent, on-going safeguarding process had all been completed and audits and reviews were up to date.

There were systems in place to share information and seek people's views about the running of the home, including relatives and stakeholders. All responses were positive from the recent quality assurance questionnaire. People's views were acted upon where possible and practical, and included those living with dementia. Their views were valued and they were able to have meaningful input into the running of the home. A resident questionnaire action plan from December 2017 showed comments were listened to, more electronic tablets had been purchased for example and there were regular resident's meetings. The cook was also about to meet with people after our inspection to discuss the dessert menu to increase choice.

We found one breach of our regulations.

You can see what action we told the provider to take at the back of the full version of the report.

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.

People were generally supported with their medicines in a safe way by staff who had appropriate training although some improvements could be made to make medicines management more robust and secure.

People benefitted from support from enough staff to meet their needs in a timely way.

People benefitted from well maintained and equipped accommodation in a homely environment.

People were protected from the risk of harm or abuse whilst independence was promoted in a balanced way.

People were protected from the spread of infection, because safe practices were in place to minimise any associated risks.

Is the service effective?

Good

The service was effective.

People and/or their representatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

Staff ensured people's human and legal rights were protected.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised care and support which was responsive to their changing needs but people's social and leisure needs were not well organised to ensure each individuals' needs were met consistently.

People made choices about aspects of their day to day lives.

People and/or their representatives were involved in planning and reviewing their care.

People and/or their representatives shared their views on the care they received and on the home more generally.

People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were now effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way. However, some improvements had only been recently implemented so we needed to make sure these were sustained and there was no audits to ensure individual's social and leisure needs were met.

There was an honest and open culture within the staff team who felt well supported by management and the provider.

Staff worked in partnership with other professionals to make sure people
received appropriate support to meet their needs.

The Firs

Detailed findings

Background to this inspection

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

This inspection took place on 6, 16 and 17 July 2018. This was an unannounced inspection and was carried out by one adult social care inspector, a specialist advisor and an expert by experience on the first day. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service. The specialist advisor is a person who is currently working in a relevant field. A pharmacy inspector also visited on 6 July 2018. 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. This inspection was brought forward because of safeguarding concerns regarding pressure area care for one person.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law.

At the time of this inspection there were 16 people living at the home. During the day we spent time with all 16 people who lived at the home and two relatives. We spoke in depth with eight people. We also spoke with the provider, the operations manager, the deputy operations manager, a team leader, four care workers, the cook and a domestic. We also spoke with four visiting health professionals.

We looked at a sample of records relating to the running of the home, such as audits, quality assurance, medicine records and care files relating to the care of three individuals in depth as well as looking through all 16 computerised care files. We discussed staff recruitment processes with the registered manager and looked at three staff files.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. The last comprehensive inspection was in September 2016; at that inspection the overall rating for the service was good and people were safe. A focussed inspection was then completed in February 2017 to look at safety issues at the service following some concerns; at that inspection we found the service was safe. At a further focussed inspection following an incident in November 2017 we found risk assessments had not been updated when a person's risks or needs changed and people were at risk because risks to people's health and safety were not always effectively managed to reduce risks of avoidable harm. Although we were aware of an ongoing safeguarding process relating to one individual, we found the care plans and risk assessments for other people receiving a service were up to date and detailed during this inspection.

Generally people's medicines were managed safely although there were further improvements to be made. People were supported to take their medicines by trained staff. Two staff members administering medicines did not have up to date records to show that they had been assessed as competent. The deputy operations manager had already arranged for annual assessments of these staff members. The staff rota indicated that agency care workers were sometimes used overnight. The deputy operations manager explained that care staff competent to administer medicines stayed late to administer people's regular evening medicines. However, they did not have assurance that the night agency care workers were qualified and competent to administer any additional medicines needed overnight. This was not commonly needed but the deputy operations manager was gathering information to assure them this was the case. Training had been booked for regular night staff to ensure medication could be given if needed at night as management could not always be sure night staff were trained to do so at present.

A medicines policy was available for staff and there was a process to record and review medicines errors and incidents, but none had been reported. Regular audits were performed but had not identified some of the issues found on inspection, however the manager's monthly audit was not due and would have picked up these issues using their checklist. The team leaders also carried out a weekly audit but this was found not to be robust as they had not picked up the issues we found during this audit, which we fed back. The operations manager was looking at this.

Care staff signed medicines administration records (MARs) after giving a medicine. Although the 15 MARs we checked were fully completed, there were some discrepancies between the stock balance and the MAR. This may indicate that people had not received their medicines as prescribed. These discrepancies had not been identified during weekly medicines audits or through stock balance checks. The deputy operations manager had since developed a daily stock check since the first day of our inspection.

Additional information was often recorded to help staff administer medicines prescribed to be given when required. For example, why the medicine was prescribed and what signs or symptoms the person may demonstrate to show it was needed. This was important for people who could not communicate their needs. However, this information was not always in place and staff were not recording the outcome of giving a medicine to show if it had been effective. During the inspection this was completed.

Medicines were stored securely, however confidential medicines records could be viewed by unauthorised persons as the treatment room was left unlocked. We saw this unlocked during the first day of our inspection. By the second day, the manager had ordered a key code lock for further security. Records showed that the maximum temperature of the medicines fridge had been above the safe temperature for storing medicines every day since 15 June 2018. No action had been taken and it was not clear if staff knew how to reset the fridge thermometer. This was a faulty thermometer and a new one had now been purchased showing the fridge was at the correct temperature.

Recommendation: medicines audits and governance checks should be designed to identify the issues raised on inspection. Senior leaders and the manager should identify and act on issues raised.

Staff communicated with a range of healthcare professionals to ensure that people were taking their medicines safely, including arranging for medicine reviews and checking medicines received when a person was discharged from hospital.

People and relatives told us they felt the home was safe and they were well supported by staff. Comments included, "They make sure mum always has her call bell on hand, she is happy in her room with the TV. I can leave here and know that mum is well looked after. They brought her flowers from the garden and pop in for a chat" and "He is very happy now. I think [the registered manager] is doing a wonderful job here. I have seen a really big change. When I first brought him in the bedding was very uninviting, unkempt. It's now been brought up to this, and I am happy with the standard. They are safe, yes."

The provider and management team had systems in place to make sure people were protected from abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected. Any safeguarding concerns had been managed well with provider involvement, and the service had worked openly with the local authority safeguarding team. Relatives said they would speak with staff if they had any concerns or issues, and that these were addressed. People seemed happy to go over to staff and indicate if they needed any assistance. Some people were not able to respond directly about their experiences due to living with dementia but appeared happy and comfortable with staff and each other.

Staff encouraged and supported people to maintain their independence in a caring way. Most people only required one care worker to assist or prompt them. Staff checked if people had managed their clothes appropriately for example, helping them to change in a discreet way if needed. Care staff ensured they prompted people to dress themselves and assisted with ensuring people dressed in the correct order. People were wearing appropriate clothes for the weather.
The balance between people's safety and their freedom/choice was well managed. Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help if they needed assistance. Where people were at risk of recurrent urine infections which could affect their safety such as mobility, dementia and cognition, staff were vigilant in ensuring prompt health professional assistance and ensuring the person had appropriate treatment to keep them safe.

Risk assessments and subsequent preventative actions for staff to take were included for risk of pressure area skin damage, falls and nutrition. We looked at all 16 people's risk assessments online and these had all been recently reviewed and were up to date. There were alerts shown on staff handheld care plan devices for people who had been identified as being at risk of pressure damage. For example, these ensured staff checked that people at risk of pressure damage moved their position, especially for the two people who preferred to stay in bed. Computer records alerted staff when a change of position was due and recorded

the time the task was achieved. We saw staff check one person in a chair in the lounge regularly, as well as ensuring they had a pressure relieving cushion. Records showed good information about the application of topical creams (these had been labelled with the date when opened except some brought in by family which was addressed during the inspection). Care records stated where creams were to be applied such as "To be applied daily during personal care to coccyx for psoriasis", "To apply to sacrum after every pad change, pea size" and "Apply morning and evening to legs, feet and heels before fitting compression garments, two pumps of cream for each leg."
There were new body map records and a new body map folder and information for staff on how to manage moisture lesions. Where people required pressure relieving equipment to maintain their skin integrity, staff ensured cushions, for example, were moved with the person when they moved and people were using pressure relieving mattresses where appropriate. These were monitored to ensure the settings were correct. When we visited people, their care was as the care plan and risk assessments stated. Two people had vulnerable heels which were being managed and two people were visited by the district nurse for moisture lesions which were also well managed.

There were risk assessments for the prevention of falls. These included what equipment and how people should mobilise safely. Risk assessments since the recent individual safeguarding process now included the exact sling size to use should anyone fall and require the hoist. The majority of people liked to mobilise independently. Staff were visible and noticed if someone was not using their frame. People who lived upstairs had risk assessments about how they accessed downstairs. We saw them using the stairs as stated in their risk assessments. One person had moved downstairs as staff had recognised they were less stable on the stairs. They were happy walking around the spacious downstairs areas. We looked at falls records from May 2018 to July 2018, which were not excessive. Where people had fallen, this had been evaluated and appropriate referrals made in a timely way, such as to the occupational therapist. There was a falls checklist and flow chart to show staff what to do. We saw no signs of any regular patterns to people's falls, they were mostly due to people who could ask for assistance trying to do something independently and this had been analysed.

Moving and handling risk assessments were detailed. For example, "I am able to weight bear but I am anxious when standing and have a tendency to lean backwards so I use a stand aid." And "I need to be prompted to hold onto either side of the stand aid." Behaviour risk assessments and development plans were in place to guide staff to identify triggers that may affect a person's behaviour and how to safely manage that behaviour in the least restrictive manner. Medicines specific mental capacity assessments were recorded to identify when it would be in the person's best interest to give a medicine during a distressed period. People's behaviour was not controlled by excessive or inappropriate use of medicines.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. Agency staff rarely used and shifts were covered with regular staff who mainly worked 12 hour shifts for consistency. Staff were able to meet people's needs in a timely way and had time to take meals with people and sit and chat for some time. Most people could use their call bell. Those who could not due to living with dementia, were included on staff care plan alerts on their hand held care plan devices. This ensured, although there were not staff in the lounge all the time, staff regularly visited to ensure people did not need assistance. Most people could mobilise. Staff also had time to check people who required assistance with maintaining their continence, which was well managed.

During the inspection the deputy operations manager was sourcing a longer lead call bell for the lounge as the call bell point was behind a curtain. One person who remained in bed said, "The care staff normally respond to call bells within five minutes, if they are going to be any later they often go into my room and let me know. They were happy with this arrangement.

Staff duties were allocated at the start of a shift, including ensuring people received adequate fluids during the day and to assist the district nurse. Staff felt they had time to complete tasks without rushing as well as spend time with people. People looked well cared for and happy and we did not hear call bells ringing excessively. Staffing numbers were determined by using a computerised dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although these remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became agitated in the lounge so they went for a walk with staff. Another person made noises which staff knew indicated anxiety, so they sat and spoke to them and reassured them.
The home was clean and tidy and there was a programme of on-going refurbishment and decoration. There were no offensive odours throughout the home and rooms were fresh. Staff used personal protection equipment (PPE) when delivering care and changed aprons and gloves between rooms or when dealing with food. Staff had had training in infection control. A maintenance person was available who checked the maintenance book regularly for requests for repairs ensuring the home was well maintained and homely. The kitchen had a food hygiene certificate of five stars, which is the highest rating from the environment agency.

People were protected from the risk of harm or abuse because safe recruitment procedures had been followed. We looked at the recruitment records of three staff who had been recruited since the last inspection. These showed that risks of abuse to people due to unsuitable staff were minimised because the provider carefully checked prospective new staff to make sure they were suitable to work at the home. These checks included seeking references from previous employers, photo identification and carrying out Disclosure and Barring Service (DBS) checks. These checks made sure the applicant had not been barred from working with vulnerable people, and they did not have a criminal record that indicated they put people at risk of harm.

The provider had systems in place to manage emergency situations such as fire. Each person had a personal evacuation plan (PEEP) to enable emergency services to know how to manage people. Accidents and incidents were recorded to show they were well managed and appropriate actions taken.

Good

Is the service effective?

Our findings

At the previous inspection in March 2017, we found this area was Good. At this inspection in July 2018, this area remained Good.

The service was effective. Some people who lived in the home were not able to choose what care or treatment they received due to living with dementia. Therefore the staff and management team had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments had been carried out or recorded to determine each person's individual ability to make decisions about their lives. Where restrictions were in place appropriate applications had been made to the local authority to deprive the person of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005.

DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Where people were restricted, for example by the use of bed rails, best interest decisions had been made in consultation with other people involved in their care, and the decisions had been recorded. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff were aware of the implications for people's care which was recorded in each care plan and had also included discussions with one person who had capacity to decide they did not want as regular checks during the night. Another person was very happy remaining in bed so staff had ensured they were kept safe and their pressure areas were all intact. Throughout the inspection staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes such as one person liked a snack before bed.

Staff gave us examples of how they communicated with people who were unable to verbally communicate and explained how they used hand gestures, facial expressions, pictures and written word to support understanding. Simple language was used to explain and involve people. Staff offered people living with dementia simple choices, putting out different clothes for people to choose for example, or showing them different plated meals. One person particularly liked to sing, so staff sang with them. Another person had a profound hearing loss so staff used a notepad to write questions down which enabled the person to participate in discussions.

The provider ensured people had accessible information in line with the Accessible Information Standard (AIS). Care reflected people's diverse needs and social situations. Care plans and information could be provided in larger fonts and the management team was looking at how the accessible information standards could be further incorporated into people's care (The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.) For example, kitchen staff were looking at offering a wider range of desserts they could show people as people did not proactively ask for an

alternative. Staff used electronic tablets to show people and relatives their care plans so they could use large font and highlight areas whilst going through them. This showed the staff team cared about ensuring the service was inclusive.

People and relatives all said they thought the staff had the correct skills and training to meet their personal needs. Comments included, "They know what they are doing", "They are very helpful", "The staff are brilliant, they will do anything for you", "They make me feel comfortable" and ""I have a shower whenever I care to have it."

There was a stable staff team at the home who had a good knowledge of people's needs. Most staff had been employed at the home for a number of years. Staff and the management team were able to tell us about how they cared for each individual to ensure they received effective care and support. For example, we discussed each person with staff and their responses reflected the care plans. They said they were pleased one person had not had to have any medication to keep them calm for a long time. The person was now happy pottering around chatting to staff. One person liked particular music so staff planned to buy a suitable CD. They knew one person was at risk of weight loss and didn't like milk so they found other alternative snacks. Another person liked certain staff so they were matched together and during the inspection they were 'working' with their 'favourite' care worker, organising the visiting clothes shop. The service had booked a mobile clothes shop to visit so people could buy new clothes with staff assistance if needed.

Staff knew who were expecting visitors that day and reminded people who was coming if they were anxious. There was good communication, with shift handover notes kept on the computer system, where a red flag alerted staff to any recent changes in people's needs since the last shift. Staff carried out a wellbeing check first thing on a shift to check everyone was ok. Any changes were flagged up, although the deputy manager amended any changes in risk assessments and care plans, the team leaders were being trained to do so. Any changes would appear on the handover document from the computer system. A checklist ensured all staff used the same care buttons to show when care had been done, for example oral care. We saw this was completed.

Relatives also spoke of how the staff knew the needs of family and friends too, treating them as part of the 'family'. One relative said they liked to see how staff took time and knew what their mum liked. For example, they had arrived to find staff had bought their mum's favourite sweets. Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. There was a comprehensive training programme covering a wide range of topics. The training matrix showed staff were up to date or booked on training. For example, training was completed for training thought to be mandatory by the provider such as falls, fire awareness, first aid, food hygiene, equality, diversity and inclusion and dementia care sourced from a nationally recognised dementia specialist. A comprehensive induction was completed by new staff. Staff were able to complete the Care Certificate. This is a nationally recognised qualification for people new to working in care. Staff could access further training, for example one new staff member was being supported to study for their level 5 diploma.

Supervisions and appraisals were up to date and showed meaningful discussion enabling staff to discuss any issues, training needs and competence. Staff felt well supported. The service also offered placements for work experience for young students in health and social care to promote this career. The deputy operations manager said how the students had enjoyed a picnic with people during their placement.

People had access to health care professionals to meet their specific needs. Records showed people attended appointments with GPs, dentists, chiropodists, district nurses and speech and language therapists.

Staff made sure people saw the relevant professional if they were unwell and there were lots of recorded examples. The GP had been concerned about one person not being offered painkillers, however this person was able to tell us they had not wanted any. The deputy operations manager was also discussing the expectations between the service and the GP surgery about diabetes care. They did not currently have any people receiving insulin treatment, those with diabetes had tablet therapy and they knew that national guidelines did not support regular finger blood testing. However, this could be useful if someone became ill. The service had contacted the GP when a person was ill but did not currently carry out blood monitoring. They said they were happy to monitor diabetes in a way which benefitted people between the service and the surgery.

Staff said they had a good relationship with local GP surgery and the community healthcare team. There was now a communication book for the community nurses, who visited most days, to write in during their visits as it had previously difficult for community nurses to access the computerised care files. A visiting health professional stated they found the staff to be competent and answered questions put to them and there was a positive response from care staff when they entered the home, they saw some good interaction between care staff and people living there. A community nurse said the home and the care staff were greatly improving. They said they were assisting people with continence rather than just changing the pad which had happened in the past. We did not see poor care practices. They told us, "Staff have always been helpful. The care staff are receptive to education and learning." Staff responded in a timely way to their advice. For example, they had requested that a person have a night bag attached to their day bag, which was then in place the following day on our inspection.

Each person during this inspection had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Care plans included nationally recognised nutritional assessment tools to ensure staff knew who was at high risk of weight loss for example and what action to take. Recording of nutritional needs was computerised and showed very clearly how staff monitored all people's input and took action if there was a risk of weight loss. There were graphs to show food and fluid and weight trends and details showing how staff could encourage food in a person centred way such as offering finger foods and snacks. The GP had been concerned that staff called them often about people showing weight loss and wondered if they had considered using high calorie diets. However, this was always tried with people showing weight loss, for example buttery foods and milky drinks and included on a flow chart showing what actions to take in a simple way. The cook was trying out some high calorie milkshakes for the future too.

Everyone we spoke with was happy with the food and drinks provided in the home. All but one person was independent with their eating and drinking, other than for occasional prompting. Comments included, "We enjoy ourselves", "It's perfectly adequate. There's usually a choice. I have liked one of the things offered. There's not necessarily a choice of puddings", "You can have as much as you like" I asked if he is offered drinks and he said "as much as you like", "[It's] very tasty. They always seem to bring me what I want", "I like to eat in my room. I feel well looked after now [I'm here]. I eat better." If anything, people thought there was sometimes too much food so we fed this back to the cook who would ensure those with smaller appetites had smaller plates. They were also completing a survey to see what other desserts people would like as a few people mentioned lack of choice for desserts.

Lunch was a happy, social event with lots of laughter and banter. Most people came to the dining room, set up with laid tables and condiments, with a small number choosing to eat in their rooms or the lounge. People had different meals they had chosen, smaller plates if they wished and were offered seconds. Staff were able to understand what people would like by using their knowledge of their preferences in the past and showing them a choice of plated meals. Some people had extra butter or bread for example if they

liked. There was a varied menu. At the time of the inspection people were enjoying steak pie followed by ice cream with sauce. People were offered their choice of drinks. There were covered drink stations with dated containers and snacks available so people could help themselves or staff could assist people. Staff had risk assessed whether people living with dementia and diabetes would access these but this was not the case. Relatives were encouraged to visit over mealtime if they would like to share the experience. People were not rushed but food was served in a timely way. This all helped to make mealtimes pleasant, sociable events which also encouraged good nutritional intake. This was further encouraged as all staff ate their own meal with people at the tables.

People had the equipment and spacious environment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. The upper balcony in the hall was being fortified during the inspection as one person had been touching the spindles which had the potential to loosen them and be a hazard. There was a stair lift to assist people with all levels of mobility to access upstairs. People could access the garden through one exit. People had individual personalised walking aids so they could identify them, wheelchairs or adapted seating to support their mobility. There were enough hoists and stand-aids available and all equipment was checked weekly as well as visually to ensure they were safe to use.

Good

Is the service caring?

Our findings

At the previous inspection in September 2016, we found this area was Good. At this inspection in July 2018, this area remained Good.

The service was caring. People were supported by kind and caring staff. Staff had good knowledge of each person and spoke about people in a compassionate, caring way. They were attentive, passing time with people and relatives, often sitting down with people for a chat and a cup of tea. Staff spent time with people going for a walk or including them in their chores. Relatives told us how they always felt welcomed and all staff were able to give them an update on their loved one. We heard staff talking to one relative about how their hospital appointment went and that they had now recovered from feeling car sick.

Tea and biscuits were offered throughout the day including to relatives. One relative was enjoying tea and cake with a group of people. They said she and other family members were made to feel welcome and were always offered a hot drink on arrival. People commented, "You can't say anything about it that's wrong. It surprised me how nice it is [the home]" and "I do feel if there was anything wrong they would try and put it right for me." They told us how a care worker had noticed they had not had their newspaper so went to get it for them. People added, "I think they look after me very well", "Yes, indeed [I'm looked after well]. It's a big point about it, you can always get some help."

People's care plans detailed family and friends who were important to them and those with authority to make decisions on their behalf. This helped staff to be knowledgeable about people's family dynamics and enabled family members to be involved as they wished. For example, this knowledge had helped staff to recognise where a family member may not have been acting in a person's best interests so they raised the issue through the appropriate safeguarding processes. People and their relatives were encouraged to express their views and be involved in all aspects of care. Regular reviews with people and those that mattered to them were in place.

There were regular residents' meetings which were attended by people and relatives. Minutes showed people were able to openly comment. There were discussions about the menu, a recent event, how daffodils were in vases for spring and the newly decorated lounge with prints of the local area. One person had said they would like a beer and another person commented they enjoyed children in the home. The person was now having regular beer with their meals and a recent event invited families and children for a care home open day. This showed people were listened to.

People felt their privacy and dignity was upheld. We saw staff knocking on people's doors and waiting for a response before entering. Night staff used dim torches to help them carry out checks on people during the night, so as not to disturb them whilst asleep. People said, "They knock on the door. They never enter my room without knocking. They are very good", "I haven't come across any problems", "They always knock on the door. They don't leave me on my own." People thought staff were friendly and polite. One person said, ""They [staff] comforted me when I first came. My husband had just died. They were lovely. They are brilliant, always there if you need help. We have a laugh." Rooms were very personalised. Relatives said they

could decorate them as people wished. There was a good laundry service with care taken of people's belongings, staff were reminded to continue this in staff meetings and new name tags had been ordered.

We saw staff on several occasions talking in a kind and gentle manner with people. The housekeeper clearly enjoyed chatting to people and there was lots of banter, which people enjoyed . One care worker noticed one person making a repetitive noise whilst at the dinner table, (a sign that they were getting anxious) the care worker got on their knees (so at eye level to the person) and spoke very gently to them about topics that they obviously knew they would be interested in, as a form of distraction. The person was then smiling and listening to the music. Staff were sourcing an electronic device that would enable them to access a wide range of music for people as well as reminiscence material. They were also ordering particular CDs for people they had noticed singing, such as Doris Day. Where staff had communicated with one person with a profound hearing loss using a notepad, there were lovely messages saying, "Day staff will help you in ten minutes", "Good night, hope you have nice dreams!", "[Staff name] is on holiday for a month" and "Let's drink some more shall we?"

Staff understood people's needs and spoke in a caring way about them. Staff told us how pleased they were when people's health had improved. One person had put on weight and another person was less anxious. One person was described as enjoying looking after people. Staff ensured they felt useful, whilst checking people they were with were happy with their company or holding hands. Staff understood their dementia meant they thought their mother was upstairs. They chatted about this and the person appeared very happy. Staff supported people's relationships with each other. They knew who got on with who and who liked to be private. This helped to minimise any behaviours which could be challenging due to people's different experiences of dementia.

For one person, 'no' definitely meant 'no' and they knew to return later to offer to assist them with personal care, giving gentle encouragement. Staff knew what people liked to do and although activities were not well organised or audited, staff told us how they often came to the service on their days off to take people out shopping or to a local fete. Staff acted in a caring way which showed people that they mattered and were valued. Visitors had left comments on forms in the foyer. Comments included, "It's nice to see the changes at The Firs, the garden is looking good (staff told us they had helped with weeding)", "[Person's name] is looking happy and settled thanks to you all for caring and the love" and "Excellent staff, lovely and friendly." The regular entertainers had written, "We love this place so much, one of the best homes we do!"

The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly to maintain their privacy and dignity. Staff supported people who were in pain or anxious in a sensitive and discreet way. This included thinking about whether there may be a physical reason why someone was not behaving in their usual way. For example, a possible urine infection. Staff told us how they regularly checked people in their rooms, which we saw and this was also included on alerts to check on staff handheld devices within care plan tasks for those people. When staff had not been working for a few shifts they were genuinely pleased to see people, chatting about how they had been and sharing what they had been doing. Some people were unable to communicate directly and staff sat with them singing or chatting about topics people responded to.

Staff understood the need for confidentiality, the safe storage of people's records, and knew not to share information without people's consent or unnecessarily. However, there were issues with the medicine room being left open and accessible with records unsecured.

Requires Improvement

Is the service responsive?

Our findings

The service is not always responsive. In March 2016 we made a recommendation that the service sought advice and guidance on developing activities for people living with dementia. This was because there was not an established and regular range of activities to meet the social needs of all the people living at the home at that time. At this inspection, we found that although staff spent time with people, some activities were offered and there was a low risk of social isolation, this did not mean that people were enabled to take part in meaningful activities on a regular basis. There were no audits about how people were spending their day and activities, although offered by staff and external entertainers, did not ensure each person had their social and leisure needs met.

Lack of a range of activities had been commented on in the residents' questionnaire in December 2017 and the action plan said new activities had been introduced and people all appeared to be happy with what was provided. However during our inspection, some people told us , "I would like to have quizzes, anything that gives you something to do"; "Sitting in the conservatory, there's not much else to do. I would like a nice big seed catalogue. It would be something to read. I would like to go out. They never have time to take me" and "They need to improve the activities." One person said they were not routinely informed of any activities.

There was not an activity co-ordinator at the service and the staff allocation sheet showed a named care worker was designated to offer activities. However, this was in addition to their usual care work and tasks. Although we found staff were not rushed and able to spend time chatting to people, this was ad hoc and depended on whether people approached staff or if staff had time. We found there were activities offered. For example, there was an activity programme on the notice board. Each morning armchair activities were on the programme. However, on both days of our inspection these were not offered because the care workers were busy with visiting health professionals or one person who required additional support.

On both days there was a cheerful, chatty atmosphere and people were noticed by staff but there were no meaningful activities offered in a consistent way to ensure each person had their social and leisure needs met. For example, two people who were quieter sat in the lounge all day, punctuated by meals and support from staff. Another person moved around the home all day but had no other meaningful occupation. Only one person went outside over two days of the inspection despite the good weather.

Activity records were of a tick box nature on the computer care plan but they were not consistently filled in. Within the recent safeguarding process it had been recommended that staff complete 'This is Me' documents with people and families to ensure staff consistently had information about people's backgrounds, likes and dislikes. Five of these had been completed and were full of personalised information but this had not yet been used to meet people's individual needs. We looked at one person's care records and for two days there was no activity recorded , although they did spend short periods talking to staff. On the second day of the inspection a care worker spent time in the afternoon colouring with three people and one person went for a walk in the garden but no-one else had any meaningful activity other than the TV on in the lounge. Here, four of the five people on both days in the lounge had their eyes shut or looked bored.

However, the service had started to provide some activities. External entertainers visited, 'Pets as Therapy', a national open day was held and staff told us how they sometimes went for a walk, shopping or out with people. They tried to include some people in their tasks and did not ignore people. However, these events were not organised to ensure each person was able to be occupied in some way that met their individual needs. The deputy manager was aware of these issues and was going to raise this with the provider, suggesting that an activity co-ordinator was appointed. People said they were able to arrange to go out with family and friends, although there were few organised trips out. People said the staff always asked them how their day had been.

The lack of meaningful, personalised and regular activity does not ensure that people's social and leisure needs are met and is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care

We looked at the records of people living at the home at the time of the inspection. People had been assessed before they arrived at the home. The service undertook their own comprehensive assessment of people's needs to ensure they were able to meet them. Care plans were then developed to incorporate people's needs. The deputy operations manager assured us the provider's policies ensured people were treated equally and fairly. The assessment process also helped to identify when staff may require further training before they were able to support people, for example for a specific medical condition. If people were coming home from hospital, the service ensured all the necessary equipment was also in place to support a safe transition.

People received care and support that was responsive to their personal care needs because staff had good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. People were involved in discussing their needs and wishes if they were able and people's relatives also contributed.

Care plans were computerised, easily accessible for staff on password protected electronic tablets to keep up to date and good records. These support plans we looked at showed person centred language and gave good detail about exactly how staff should care for people. For example, staff were vigilant about people's relationships and behaviours with others and knew how to manage them to minimise distress. One person was having new medication and this was well documented to show health professionals how it was affecting the person's behaviour." Continence care for example, detailed what signs people may make to show they needed assistance to the toilet such as "fiddling with my waist band" . We saw staff recognise this and act promptly.

Records showed that staff responded to the changing needs of people who were at the home. . For example, staff recognised when people were not eating so well or were not themselves. Health professional records showed staff had spoken to appropriate health professionals in a timely way. For example, to gain advice about a puffy eye, to report dry skin requiring cream and for advice and equipment to make it easier to take a urine sample which they knew could affect dementia. One person's legs had healed nicely, according to the community nurse. Staff were described by the community nurse as doing a good job putting ear drops in and the person's hearing aid could now be re-fitted. We spoke to all staff who were very knowledgeable about people's needs. There were regular reviews of people's health. Each person had a 'hospital passport' that could be printed from the computer care file.

Some people were unable to be directly involved in their care planning but relatives were able to be involved if they wished. Relatives felt they were able to chat to staff or the management team at any time. People and their representatives knew how to make a formal complaint if they needed to but felt that issues

would usually be resolved informally. The registered manager had discussed putting up a photograph of who to speak to about a complaint to make it easier for people to understand. There had been few formal complaints this year and these had been managed well. Issues were taken seriously and responded to in line with the provider's policy.

There was no-one receiving end of life care during our inspection. Staff were involving families in adding end of life information within the care plans as an on-going process. For example, whether people were for resuscitation, what their wishes might be and information about power of attorney and arrangements. Staff knew how to access health professional support and equipment such as hospital beds or medicine 'just in case' bags. Staffing levels could be increased if needed to provide additional support for people at the end of their lives. Appropriate health care professionals and family representatives had been involved in end of life discussions. Staff attended people's funerals and there were thank you cards from grateful relatives.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. In March 2016 we recommended that the service sought advice and guidance on developing activities for people living with dementia. This was because there was not an established and regular range of activities to meet the social needs of all the people living at the home at that time. We found that although staff spent time with people and there was a low risk of social isolation, this did not mean that people were enabled to take part in meaningful activities on a regular basis. There were no audits about how people were spending their day and activities, although offered by staff and external entertainers, did not ensure each person had their social and leisure needs met. Therefore, despite knowing that the organisation and provision of activities was not meeting individuals' needs, this had not been addressed.

In November 2017 we found during a focussed inspection that the service had not submitted statutory notifications to the Care Quality Commission when particular events had occurred and checks and audits were carried out routinely but these had not always identified issues that were found during the inspection. In November 2017 care plans did not always fully reflect people's risks and needs when changes occurred. When incidents had happened, plans did not always take into full consideration how to reduce the risks of recurrence. During this inspection in July 2018 we found people's care plans were detailed and identified risks, safeguarding issues were identified, we received notifications as legally required and audits were good. However, we were aware of an on-going safeguarding process relating to pressure care. As a result of this process the service had recently completed a number of minor improvements such as improving records such as body maps and oral care, raised during that process. Therefore, we have rated this area as requires improvement to give the service time to assure us that the improvements will be sustained and that people's leisure and social needs are met in a person centred way. The whole home safeguarding process was closed on 16 August 2018 and the provider was showing good progress.

Other than for activities, there were effective quality assurance systems in place to monitor care and plan on-going improvements. Provider governance was well managed with regular monitoring of a range of topics such as records, care reviews, falls and incidents and medicines. Although we found some minor issues relating to medicines, these would have been identified using the manager monthly audit which was due. The deputy operations manager had now ensured the weekly team leader audit was more robust and that care records and risk assessments could be updated by all team leaders and night staff not just the manager. However, information was known to staff when there were changes through the handover and communication methods. The provider was making improvements in some aspects of care as part of the safeguarding process.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. For example, where people had fallen, individual risk assessments were reviewed and preventative measures taken such as referral to an occupational therapist.

There was a management structure in the home which provided clear lines of responsibility and accountability. People and relatives told us the culture at the service was positive. The Firs philosophy was

to encourage choice and independence and we saw this happening during our inspection. There was a happy atmosphere with people being well cared for, noticed and people going about their day as they wanted. The provider came to support staff during the inspection and the administration auditor also arrived to carry out their regular audit and follow up on previous improvements which had been completed.

The deputy operations manager was open, transparent and person-centred and keen to do their best for people. People knew who the management team were and met regularly for 'Tea with [registered manager's name]' so people knew who they were. Managers had worked within the company for some years. Managers were always available across the week and there was an on call system for out of hours. People and relatives said of the management team, ""She is very, very nice. I am quite happy with everything now" and "She has made lovely improvements (talking of the décor)".

There were systems in place to share information and seek people's views about the running of the home as well as relatives, external stakeholders and professionals. A recent quality assurance survey had been completed and an action plan devised, for example to improve dessert menus and continue with particular activities.
The managers had an open door policy and they were available to relatives, people using the service and health professionals. The office although small was in a prominent area and there were quieter areas to meet.

All staff were positive about working at the home. Staff received regular supervision support, and felt they were regularly listened to and consulted through staff meetings. The registered manager and provider had a range of organisational policies and procedures which were available to staff at all times. The provider's whistleblowing policy supported staff to question practice. It defined how staff that raised concerns would be protected.

The management team understood their responsibilities. They promoted the ethos of honesty and learned from mistakes, this reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment and apologise when something goes wrong.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

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 People did not have their social and leisure needs met in a consistent and person centred way.