Ms Janet Murrell

The Firs Nursing Home

Inspection report

745 Alcester Road South
Kings Heath
Birmingham
B14- 5EY
Tel: 0121 445 6292

Date of inspection visit: 9 July 2015
Date of publication: 05/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We inspected this home on the 9 July 2015. This was an unannounced inspection. The Firs Nursing Home provides accommodation for a maximum of 25 adults who require nursing or personal care and who have mental health needs. There were 24 people living at the home when we visited although one person was in hospital. The home is set out over three floors with a lift to provide access to all floors. There are eight shared bedrooms and nine single bedrooms. Shared shower-rooms and toilets were located on each floor of the home.

The home does not currently have a registered manager. 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 living at the home and their relatives told us they felt safe and said the staff were very caring. Staff knew

Summary of findings

how to recognise and report potential abuse and told us they could speak to the manager if they had any concerns. People had access to regular healthcare checks in order to maintain their health needs.

The manager had conducted assessments to identify if people were at risk of harm. However, people were not always protected from harm as these risks were not acted on to reduce the risk of harm to people.

People living at the home and their relatives told us that there were enough staff to meet people's needs. However, we saw that people were left for substantial periods of time with little or no interaction and that people who were at risk did not have enough staff available to support them.

The Mental Capacity Act 2005 (MCA) sets out what must be done to protect the rights of adults who may lack the capacity to make certain decisions for themselves. Whilst staff had received training about MCA we found that there was a lack of understanding from the provider and staff about what this meant for people living at the home.

People were supported to eat and drink sufficient amounts to meet their needs and maintain good health. People told us they liked the food and were given a choice of meals.

People were not always treated with respect because they were not always involved in planning or providing feedback about their care. We saw that care plans had been reviewed but not always with the person. We saw that, at times, staff acted responsively to peoples requests. People and relatives told us that if they had any concerns or complaints that they had been dealt with appropriately.

People knew who the manager was and said they felt he managed the service well. Staff said that they felt supported within their role.

The systems in place to monitor the safety and quality of the service were not robust and placed people at risk of reoccurring incidents or events. The current systems and checks did not measure the quality of the service and did not effectively identify areas of improvement.

The provider was not meeting the requirements of the law in respect of some regulations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not protected from avoidable harm. Medicines were not always given safely.

Staff were not always deployed effectively in order to meet people's needs.

Staff knew how to recognise and act on the signs of potential abuse

Requires improvement

Is the service effective?
The service was not effective.

People's legal rights were not consistently supported by the home.

People had access to healthcare when necessary in order to maintain their health.

People were supported to eat and drink sufficient amounts to maintain good health.

Requires improvement

Is the service caring?
The service was not always caring.

People and relatives felt that staff were caring. Staff knew the people well.

People were not always involved in decisions about their care.

Requires improvement

Is the service responsive?
The service was not always responsive.

There were times when people had limited opportunities to engage in activities, and when activities were provided they were not in line with peoples interests.

People felt able to raise concerns and we saw that complaints had been handled appropriately. However the complaints procedure was not in a format accessible to all people.

Requires improvement

Is the service well-led?
The service was not well-led.

There has not been a registered manager in post since August 2014.

Quality Assurance systems were not robust or effective and had failed to identify where improvements were needed in management of risks and provision of person centred care.

Requires improvement

The Firs 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 unannounced inspection was undertaken by two inspectors.

We visited the home on the 9 July 2015 and spoke with six people who lived there, five members of staff, the manager and the nominated individual for the service. 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 about their experience of living in the home. After the inspection we spoke with three relatives and one healthcare professional who supported people who used the service.

Before the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us and any other information we had about the service to plan the areas we wanted to focus our inspection on. We also contacted the local authority who commission services from the provider for their views of the service.

We looked at records including three peoples care plans and medication administration records. We looked at two staff files including their recruitment process. We also sampled records from training plans, resident meetings, staff meetings, incident and accident reports and looked at the providers quality assurance records to see how the service assessed and monitored the quality of the service.

Requires improvement

Is the service safe?

Our findings

People who we spoke with told us they felt safe. Three relatives we spoke with said that staff were approachable if they had any concerns and did not raise any concerns about peoples safety. Staff we spoke with could explain the provider's safeguarding procedures and said they had received training in how to recognise the signs of abuse and described how they would take action to keep people safe. Staff said they would report any concerns to the manager. Records confirmed that staff received safeguarding training to ensure they were knowledgeable about safeguarding practices.

Staff we spoke with could explain how they supported people so as to reduce the risk of harm associated with their specific conditions. We saw that staff supported people in line with these explanations. For example, we observed a person being supported by two members of staff when they transferred from a chair to a wheelchair. During this time the staff explained to the person what they were doing in order to minimise their anxiety and ensure they were moved in line with safe practice.

We looked at three peoples risk assessments. These included assessments for people who had experienced falls. We found that the manager had not always responded appropriately when they had identified people were at risk of harm. A falls risk assessment for one person who had recently suffered several falls, had not been reviewed after each incident and there was no updated guidance for staff about how to reduce the risk of the person falling again. We also found that one person had been initially assessed by the provider as being at high risk of choking. The manager had not sought specialist advice from a healthcare professional on how to support this person to reduce the risk of them choking and there was no specific care plan in place to manage the risks. Following the inspection the provider told us they had commenced seeking advice from a healthcare professional for this person. We found that there was no information available about medical emergency treatment for two people's health conditions which meant that staff could have inconsistent approaches to emergency situations. The arrangements in place for management of risks were not effective in protecting people from avoidable harm.

People who used the service and their relatives told us that there were enough staff to meet people's needs. Staff and most of the relatives we spoke with commented that although several members of staff had left the service recently that there were enough staff currently working at the service. We saw that when necessary the provider had access to additional agency and bank staff to ensure that designated staffing levels were maintained. All the staff we spoke to said it was rarely necessary to require the support of agency staff. We saw that staff responded promptly when people made requests for support.

We saw that although there were sufficient numbers of staff on each shift, they were not always deployed in an effective way in order to meet people's needs. Prior to the inspection we identified from reports supplied by the home, that some incidents, such as falls, took place when people were unattended by staff. The records of one person identified that staff should be close by when the person was walking because they were at high risk of falls. However, the manager had not increased the levels of staff support for this person and had taken no other steps to keep the person safe. One relative said they were concerned that people in communal areas were not always supervised by staff. During our visit we observed that some people in the lounges were left for substantial periods unsupervised.

There were processes in place for staff recruitment which included obtaining Disclosure and Barring Service (DBS) checks to ensure that people employed were safe to be working to support people. We noted that these were in place but other steps taken were not robust. We looked at the files of two staff who had recently started working at the service and saw that the manager had not followed up gaps in employment history or ensured they had suitable references. Therefore there was a risk that the manager employed people who were not suitable to support people who used the service.

People were supported to receive their medicines in a dignified and sensitive way. Medicines were stored safely in a locked medication cabinet and at the correct temperature. The records for each person's medication contained a photograph of the person to reduce the risk of medication being given to the wrong person. Each person's record also contained instructions for staff of when to give 'as required' medicines. However, the instructions for one persons 'as required' medication was not up to date which meant the person was at risk of receiving an incorrect dose of their medication. The prescription labels for one person's daily medication were also not up to date which

Requires improvement

Is the service safe?

placed the person at risk of receiving incorrect amounts of medication. Immediately following the inspection the provider contacted us to inform us that this had been rectified.

Requires improvement

Is the service effective?

Our findings

People who used the service said that staff had the skills and knowledge to meet their care needs. Relatives we talked to told us that staff had the necessary skills to care for people effectively. One relative told us that staff, "Know what they're doing," in relation to a person's specific care needs.

Staff told us that they received induction training and were informed when there was other training they had to attend. Staff said they had enough training to be able to support people's specific needs. We saw that specific training was provided to staff so that they could continue to support people when their needs changed. We saw a training plan in place for staff. However, some of the training was poorly attended and there were no systems in place to re-schedule this training for staff who didn't attend. This meant there was a risk that staff were not maintaining the skills and knowledge they needed to support people effectively.

Staff told us that they had supervisions which helped them improve their knowledge and enabled staff to understand what was expected of them. We saw that formal supervision opportunities occurred infrequently and did not have a consistent format to follow with each staff member. We saw that staff meetings had not occurred for several months and were poorly attended.

People we spoke with felt that staff offered them daily choices and we saw staff respond to these requests effectively. We saw staff seeking peoples consent around medication and before supporting them with meals. The provider was replacing blinds in several people's rooms. However, they told us that they had not consulted with the people who occupied the rooms about the colours or designs.

We looked at whether the provider was applying the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) appropriately. These safeguards protect the rights of people using services who may lack the capacity to make decisions for themselves. Staff we spoke with told us that they received training on MCA and DoLs. However we found that there was a lack of understanding amongst staff and the manager about supporting people in line with the requirements of the MCA. This lack of understanding meant that people were at risk of receiving inconsistent support and people's rights were not being protected.

We found that the manager restricted the number of cigarettes people could have and when they could smoke them due to some people's health conditions and financial considerations. There was no evidence that these arrangements had been agreed with the people who smoked or any acknowledgement by the manager that this could deprive people of their liberties. When we looked at peoples care plans we saw that in some instances such decisions had been made for people without enabling and supporting them to understand how proposed arrangements would support and assist them to make these decisions. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported to eat and drink sufficient amounts to meet their needs and maintain good health. We saw people being offered a choice of meals and a choice of where to sit. People told us they liked the food and said the, "Food is very good," and "I like the food." We saw positive interactions between staff and people at mealtimes and extra support was given when people needed it. One person's dietary preferences were not reflected in the planned menus although we were told that this person's needs had been catered for in the past. Meal times were provided in two sittings, based on the support needs of people. We noted the dining room was cold and one person who used the service complained that the dining room was cold. People were not offered hand wipes before or after the meal so they could freshen up and prevent the risk of infection. This did not enhance people's dining experience. Staff did not notice that a person who arrived for lunch after their allocated meal time was only offered a pudding and therefore was at risk of not receiving suitable nutrition to keep them well. We pointed this omission out to staff who provided the person with a hot meal. This meant that meal times were not always effective in meeting people's needs.

We saw that a nutritional assessment had been completed for one person which concluded that the persons eating and drinking needed to be monitored to ensure they achieved a healthy weight and consumed enough fluid each day to avoid dehydration. This assessment had been

Requires improvement

Is the service effective?

reviewed three months ago. Staff told us they weren't aware they needed to complete monitoring records for this person and therefore the person was at risk of not receiving suitable quantities of food and drink to meet their assessed needs.

Relatives told us that if their family member was unwell then staff would let them know. We saw that people had access to regular healthcare, when necessary, in order to maintain their health. We saw that there was general information available about people's health conditions.

Requires improvement

Is the service caring?

Our findings

People felt cared for and we saw that staff interacted with people in a kind and compassionate way.

People we spoke with told us that the staff were nice people and, “They do look after me very well,” and, “It’s nice living here.” Relatives of three people commented that the staff were very caring and that their relative was well looked after. Staff we spoke to said that, “Caring for people is our prime concern”. We saw the interactions between staff and people were positive and staff spoke in a friendly manner with people.

Staff we spoke with were able to explain some people’s life histories but not most. We looked at records of three people who used the service to determine if people’s values and beliefs had been recorded. Two of these people had not had their life histories recorded and one person’s record contained information that was not relevant to their life history.

We found that people were not always offered a choice about how they wanted their care to be delivered. The majority of people living at the home shared a bedroom but there were no assessments completed to determine if people who shared rooms had compatible needs or if they had chosen who they would like to share a room with. One person had a specific health condition but no consideration had been given to how it could impact on the person they shared a bedroom with. We spoke to the manager about this who acknowledged that this health condition had impacted on the other person who shared the bedroom. Shared bedrooms had little or no personal belongings on display and it was difficult to determine which part of the room belonged to the person. Staff told us that they brought new clothes for the residents to wear. When we spoke to people they told us they were generally happy with the selection. One person told us , “[Staff] don’t always ask my opinion.”

We saw that information around the home was only available in written form. The manager told us they had not carried out an assessment to see if this met the individual communication needs of the people who used the service. We found that people had limited opportunities to be able to express their views and needs as there were no other communication aids available for people to use.

People were not always treated with respect because they were not always supported to make decisions about their care. We saw that there was limited evidence of people being involved in planning their care although relatives told us that they were involved in peoples care. One person had made reference of wanting to be involved in their care planning but there was little evidence that this had happened. We found that although one person had been supported to purchase specialist skin products other people looked unkempt and had not been supported to receive personal grooming to support their dignity. There was no guidance available to inform staff how to encourage people to maintain their appearance.

Relatives told us that they could visit when they wanted to. However, one relative told us that there were no private areas to go to when they did visit and that this sometimes upset their family member.

Requires improvement

Is the service responsive?

Our findings

People told us that they felt the service responded appropriately to their care needs. We saw that when staff were available they acted promptly to people's requests for support. Staff had supported one person to be reunited with their family following a long absence. Relatives told us that people had plenty to do.

Social activities were provided intermittently but were not always in line with peoples interests. People told us, and we saw, that people were supported to attend local amenities and social clubs. However, during our inspection we saw a number of times when people had little interaction or contact with staff. On several occasions we saw people standing doing nothing with no interaction from staff and no activities were on offer for them to join in.

Most of the people spent time in communal areas of the home during the day. We saw that there were televisions on in each of the lounges both showing the same programme. People who were watching the television in one lounge were unable to tell us where a remote control was to change the television channel; a member of staff we asked did not know either. Therefore, people could not change the television programme had they wanted to.

People we spoke to told us about their life histories and one person said they would like to use the skills they had learnt in life at the home. The manager was unaware of the person's desire to help around the home. We saw that some people's views were sought through residents meetings and surveys. These meetings informed people how they could complain if they were not happy. When people had requested something at these meetings we saw that it was acted on. However, these meetings were not attended by all residents and there was no evidence to suggest how the views of people who didn't attend were sought.

A new format for care plans had been introduced by the provider. However, the care plan did not centre around the uniqueness of the people who used the service and contained little information about their likes and dislikes. There was little evidence of anyone living in the home been involved in developing their own care plan which meant that people were not receiving care that was centred around them or had responded to changes experienced by people. This also meant that staff did not have access to guidance which would help to support people in ways which reflected the person's wishes. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that information was displayed in a communal area so people knew what staff were on duty, what food was for dinner and the scheduled times that cigarettes would be given out. However, there was no information available for people about how to access advocacy or community groups that people may have needed for support or had an interest in accessing.

One relative told us that the manager contacted them when their family member was upset so that they could talk to her and provide support. Another relative told us that when they shared knowledge of how to support their family member then staff acted on it. We saw a member of staff changed a person's medication times when they chose to stay late in bed. However, records showed this was not carried out consistently as medication times hadn't been adjusted on previous occasions when the person had chosen to stay in bed. People who said they liked to smoke could only smoke at designated times and not when they chose. We saw a person asking the manager for a cigarette and the request was refused because it was not at a designated smoking time, no reminder or explanation was given to the person about how they had agreed to this smoking routine.

People and relatives told us that they felt able to raise concerns if they had any. We saw that the complaints procedure was only available in a written format which meant that it was not accessible for those people at the service who couldn't read. All the people we spoke to said the manager and staff were approachable and were comfortable to express their views of the service. They gave us several examples to illustrate how the manager had responded to their concerns. We found that complaints had been handled appropriately and responded to in line with the providers own timescales. However, we noted that the provider did not have a robust system to review and analyse these concerns and complaints in order to prevent similar incidences occurring.

Requires improvement

Is the service well-led?

Our findings

People we spoke with told us they were happy with how the service was managed and staff felt supported within their role. People and staff knew who the manager was and said they felt he was approachable should they have any concerns. Staff told us that the manager supported people and staff throughout the day in the home.

The manager followed requirements to inform the Care Quality Commission of specific events that had occurred in the home and had worked with other agencies to keep people safe. However, the manager and provider had little knowledge of their responsibilities under the Health and Social Care Act 2014. They were unaware of changes to regulations and introduction of Fundamental Standards or of requirements related to use of the Care Certificate in respect of staff training. The home had few links to external groups to help them keep up to date with developments of best practice within the care sector.

There had not been a registered manager at the service since August 2014 although a temporary manager has been in place. The provider told us they were currently in the process of recruiting and expected to have a manager in place within the next few months. However, there were no records available to identify the processes that had been taken or initiated to recruit a new registered manager. The temporary manager told us they were currently in post to maintain and not develop the quality of the service, and they indicated that they had no intention to apply to take on the role permanently. The provider had failed to take appropriate timely action to comply with the requirement to have a registered manager in post. This is a breach of Regulation 5 (Registration) Regulations 2009 Registered manager condition

We found that the manager had started to use a new format for planning people's care. This format focussed on people's health and care needs. We saw that care plans were reviewed and that there was a schedule in place to carry this out. We found that this schedule was not up to date and we saw that one person's care plan did not reflect their current care needs. Care plans were not always reviewed with the person, which meant people were not involved in developing and planning their own care.

We saw that some people's views were sought through residents meetings and surveys. These meetings informed residents how they could complain if they were not happy. When people had requested something at these meetings it was acted on. However, these meetings were not attended by all residents and there was no evidence to suggest how the views of people who didn't attend were sought. The manager had conducted a survey, in February 2015, to obtain the views of the people who used the service. However they had not analysed the information received to identify what actions to take in order to improve the quality of the service.

We looked at the providers systems in place to monitor the safety and quality of the service. We found that although there were some systems in place, they were not robust. We found that the manager completed accident and incident forms but these had not been reviewed to identify how to reduce the risk of these incidents reoccurring. We found that where risks to people had been identified there were insufficient systems in place to monitor and reduce these risks occurring. For example, we found that information about behaviours that challenge did not contain details or guidance for staff in how to try and prevent these behaviours occurring.

Processes to review the quality of record keeping were not effective. The manager had not identified that care records were not being reviewed as planned or that they did not contain sufficient information to enable staff to provide safe and person centred care. We saw that there were audits in place to monitor systems around medication. However, some of these audits did not sufficiently identify and resolve issues that had been highlighted placing people at risk of reoccurring medication errors. The provider had failed to take action when staff did not attend dedicated training sessions. When staff had received training, the training had not been evaluated and the provider had not identified that it was ineffective in providing staff with the knowledge they needed to support people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not make sure that people received care and treatment that was appropriate, that met their needs and reflected their preferences. Regulation 9(1) The provider did not design care with a view to achieve people's preferences. Regulation 9(3)(b) The provider did not consistently seek the views of people who use the service about how to meet their care and treatment needs. Regulation 9(3)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 (Registration) Regulations 2009 Registered manager condition There was no registered manager in post. Regulation (5)(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. Regulation 17(2)(a) The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17(2)(b)

This section is primarily information for the provider

Action we have told the provider to take

The provider did not act on feedback from others for the purpose of continually evaluating and improving the service. Regulation 17(2)(e)

This section is primarily information for the provider

Enforcement actions

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