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Firtree House Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 07 and 08 July 2014. Breaches of legal requirements were found. As a result we undertook a focused inspection on to follow up on whether action had been taken to deal with the breaches that resulted in two warning notices being issued to the provider.

Comprehensive Inspection of 07 and 08 July 2014.

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, and to provide a rating for the service under the Care Act 2014, and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection that took place over two days. At our last inspection in February 2014 we found the service had not met the regulations in four areas. These were care and welfare of people who use the

Summary of findings

service; management of medicines; staffing; and informing CQC when people died. We received an action plan from the provider that told us they would have met the regulations by the beginning of June 2015.

At this visit the service was still not meeting the requirements for two of the four areas we had previously identified. In addition we found the service had not met the required standard of a further three regulations. This meant the service had not met the requirements for the following regulations: consent to care and treatment; care and welfare; safeguarding vulnerable adults; management of medicines; and assessing and monitoring the quality of the service. We saw that the service had improved with regards to staffing, and telling CQC when incidents happened such as when people died.

Firtree Nursing Home provides accommodation and nursing care for up to 35 older people, some of whom are living with dementia. There were 22 people living at the service when we visited. The home is made up of two floors, with access to the upper floor being by stairs or a small passenger lift. Bedrooms are spread across both floors; people with mobility needs live on the ground floor.

At the time of our visit there was no registered manager in post as they had left the service the week prior to our visit. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The newly appointed matron told us they were in the process of sending in their application to the CQC to become the registered manager.

People were at risk because medicines were not managed safely. Staff were seen to carry out appropriate checks before they administered medicines; however we saw staff leaving medicines unattended when preparing them. The system for safe storage and disposal of medicines was not effective, with overflowing sharps bins and large amounts of waste medicines in the locked medicines room.

The service had not taken the correct steps when they made decisions for people who could not make them for themselves. It was not recorded if the decisions had been made in people's best interest. Staff were not following the requirements of the Mental Capacity Act 2005.

Focused Inspection of 12 and 25 November 2015

After our inspection of 07 and 08 July 2014 the provider wrote to us to say what they would do to meet legal requirements in relation to the warning notices we had issued for Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines and Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

We undertook a focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. We found that the provider had not followed their plan and not taken sufficient action to meet legal requirements.

We identified issues with the disposal, security and record keeping of medicines which could affect people receiving their medicines. The provider was unable to show that people consistently received the right medicine, at the right time, and at the right dose.

The provider had still not implemented checks to ensure people received a good quality of care. The provider was unable to show us that feedback from people had been responded to and actioned. Policies and procedures had been updated but staff had not yet read them, so they would be unaware if they were working in line with them. Maintenance and cleanliness issues were still not identified and corrected by the provider.

The service had not met the requirements of the warning notices that had been issued, or the action plan that they submitted to us. CQC is currently reviewing its enforcement options in relation to the continuing breaches described.

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?

Inadequate

Date of comprehensive inspection on 07 and 08 July 2014:
The service was not safe. People told us they felt safe at the home, however we identified a number of concerns that needed to be put right. People were at risk because there was not a safe system for managing medicines. Although people told us they received their medicines when they needed them, we identified a number of issues with how staff prepared, and disposed of medicines.

The service did not have good systems to ensure that they met the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where decisions were made for people neither an assessment of the person's capacity, nor a record of a best interest decisions had been correctly completed. People who may be being deprived of their liberty had not had an assessment completed.

Care staff had not followed local authority safeguarding procedures at the time an allegation of abuse had been made.

Date of focused inspection 12 and 25 November 2014:
We found that the action taken by the provider had not been effective at improving safety with regards to the management of medicines.

We could not improve the rating for 'Is the Service Safe' from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection, which will take place by April 2015.

Is the service effective?

Requires Improvement

The service was not effective. Where a need had been identified to support a person the service had not ensured that the equipment used to reduce the risk of pressure sores was used effectively. Staff had not consistently recorded if they had provided appropriate care, nor had they involved appropriate healthcare professionals.

People were involved in how their care was given, and staff understood who people were, their history and what they liked.

There was a good selection of food and drink on offer throughout the day. People told us they were generally happy with the food at the home. Where people required support with eating and drinking this was provided.

Is the service caring?

Requires Improvement

The home was for the most part caring. People told us that they felt that staff treated them with dignity and respect. However we saw some instances where staff's actions showed a lack of respect for people.

Summary of findings

People told us the staff were very caring. Staff were seen to interact

positively with people, for example they took time to talk with them and make sure they were happy.

People could have friends and relatives visit whenever they wanted. They also told us they could have privacy if they wished. However we noted that people's privacy could be compromised as they were unable to lock their bedrooms or some of the communal bathroom and toilets.

The service involved people in making decisions around their care and support. People and their families were involved in reviews of the care being given. However, it was difficult to ascertain the level of involvement for people who lacked mental capacity.

Is the service responsive?

Requires Improvement

People told us the service was responsive to their needs. There were some activities on offer at the home, however during our inspection there were no meaningful activities for people to participate in and they looked bored.

When a person was unwell staff responded quickly to make them feel better. Care records showed that people received regular visits from health care professionals to check on their health.

Where requests to changes in care were made, people told us the service responded quickly. People felt comfortable raising issues with the matron, and felt any concerns they raised were dealt with quickly.

Is the service well-led?

Inadequate

Date of comprehensive inspection 07 and 08 July 2014:
The service was not well led. People were put at risk because systems for monitoring quality were not effective. Some of the concerns we raised at our previous inspection in February 2014 had not been dealt with effectively.

The management and staff had not identified a number of issues around the home that could cause injury or illness to people.

Information about providing good quality and safe care such as policies and procedures were not managed effectively. Policies were out of date, or missing.

The matron led by example and gave guidance and support to staff. They also talked with residents and family members to find out if they were happy with the service.

Date of focused inspection 12 and 25 November 2014:
We found that action had not been taken to improve the service as systems for monitoring quality were still not in place.

Summary of findings

We could not improve the rating for 'Is the Service Well Led' from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection, which will take place by April 2015.

Firtree House Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Firtree House Nursing Home.

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

The first, a comprehensive inspection of all aspects of the service, was undertaken on 07 and 08 July 2014.

This inspection identified breaches of regulations. The second was made on 12 November 2014 and focused on following up on action taken in relation to the breaches of legal requirements we found on 07 and 08 July 2014 which resulted in two warning notices being sent to the provider. You can find full information about our findings in the detailed findings sections of this report.

Comprehensive inspection

We undertook an unannounced inspection of Firtree House Nursing Home on 07 and 08 July 2015.

The inspection team consisted of two inspectors, an expert by experience, who had experience of older people's care services, and a specialist nursing advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with 12 people who used the service and seven visitors. We spoke with eight staff which included the matron and the provider. We also spoke with four healthcare professionals to get their opinion of the service.

We observed care and support in communal areas and looked around the home. We also looked at a range of records about people's care and how the home was managed. For example we looked at six care plans, eight medication administration records, risk assessments, accident and incident records, complaints records and internal and external audits that had been completed.

At our last inspection in February 2014 we found the service had breached four regulations. These were around how people were cared for, especially for those with pressure sores; management of medicines; staffing, as the number on shift did not match what the service said they needed; and failing to notify us when people had died. We received an action plan from the provider that told us they would be compliant with the regulations by the beginning of June 2014.

Before our inspection, we reviewed the information we held about the home and contacted the local social service safeguarding team and quality assurance team to obtain their views. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern and highlighting good practice.

To find out about people's experiences at the home our team talked with the people, relatives and other visitors. We observed how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Focused inspection to follow up breaches in 'is the service safe' and 'is the service well led.'

We undertook an unannounced focused inspection of Firtree House Nursing Home on 12 and 25 November 2014. The 12 November 2014 inspection was carried out by two inspectors. The 25 November 2014 inspection was

Detailed findings

completed by a pharmacist inspector. This inspection was carried out to check that improvements planned by the provider after our previous inspection had been made to meet legal requirements.

The team inspected the service against of the two of the five questions we ask about services: is the service safe, and is the service well led. This is because the service was not meeting some relevant legal requirements and two warning notices had been issued to the provider.

During this inspection we spoke with one person who lived here, three staff and one relative. We observed how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Findings from the comprehensive inspection of 07 and 08 July 2014.

At our last inspection in February 2014 we had identified an issue with how the service managed medicines. At this visit we saw that although some improvements had been made, we found further issues with how medicines were managed. We observed two instances where nurses left medication unattended. This meant that medicine was left where other people could access it. For the second example the person swallowed their medicine while the nurse was out of the room. However the nurse had not seen this, but they had signed the medication administration record to say the person had taken their medicines.

In the medicines room two specialist bins for storing sharp objects were filled above the maximum level permitted. The maximum level is there to stop the risk of people being injured by the items inside. We also found two large yellow bags of waste medication that had not been disposed of. The system to safely dispose of medication had not been effective prior to our pointing out the issues to the provider. The issues we found with regard to the management of medicines meant there was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last visit in February 2014 we had identified that staff had not recorded the level of stock for each medicine on the medication administration record. This was now being done. We had also identified that where people had refused medicines, advice from professional bodies had not been sought. There was now a clear process for recording when people had refused to take their medication. This helped to ensure that the impact to their health of not taking the medicines was clearly understood.

We observed four medication rounds over the two days. Staff carried out appropriate checks before they gave the medicine to people. For example one person needed to have their pulse checked before medication was given. Staff were able to tell us why they had to do this check and what they would need to do if the person's pulse rate was not within the specified range.

Systems were in place to protect people from abuse. The matron and staff we spoke with on the day were clear about their responsibilities about reporting abuse. However a recent incident showed that some staff had not reported an incident of alleged abuse in accordance with local authority guidance. When we made the matron aware of the issue they immediately reported the incident to the local authority. They followed best practice when they spoke with the person who used the service. They asked them what had happened, but did not ask any leading questions. This showed that the matron understood their responsibility with regard to safeguarding adults. However the staff who were originally aware of the issue had not reported the incident to the correct authorities, nor brought it to the attention of the matron. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked to see if the staff understood their role and responsibilities with regards to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLs). These are regulations that have to be followed to ensure that people who cannot make decisions for themselves are protected. They also ensure that people are not having their freedom restricted or deprived. The home's resident's handbook stated that, 'Residents are free to come and go as they please.' However people were not able to leave the building without staff assistance due to locks on the external doors. Staff told us this was done to keep people safe, as some would not understand the dangers of the busy road outside. The provider told us they were aware of the need to review people's care with regards to the Deprivation of Liberty Safeguards. They had not yet made any referrals to the local authority at the time of our visit, although a need had been identified.

In three out of six care files, assessments of people's capacity had been completed. However no record had been made about what decision it was that the person could not make for themselves. The forms were completed as a blanket statement that the person lacked capacity. Also where decisions had been made for people, no record of a best interest decision process had been recorded. This must be completed wherever a person lacks capacity to make a decision for themselves and someone else has made, or will make, a best interest decision for them.

There was guidance in the policy file that identified the key principles of the MCA and DoLs. When we spoke with staff about the MCA and DoLs we found they had a mixed level of understanding. The matron was able to describe their

responsibilities; however one of the care staff we spoke with was unable to describe what the DoLs were about. They did not know what their legal responsibilities were to ensure they did not restrict someone's freedom, or the action they would need to take if a person's freedom was being restricted.

This meant the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw examples where the provider had not identified issues within the home that could have an impact on people with mobility issues, or who may be frail and prone to infections. Staff had recorded some issues in a maintenance log, and these had been repaired. However on the first day of our visit there were a number of maintenance and cleanliness issues found, for example:

- Loose radiator covers around the home that could fall over and hit frail people if bumped into;
- A broken radiator cover in a main corridor with screws exposed which could cause injury if someone fell over;
- A carpet that had been damaged in a bedroom of a person with mobility problems, leaving a trip hazard;
- Liquid soap and paper towels were not available in one of the sluice rooms, so staff could not effectively wash their hands to reduce the spread of infection;
- Cleanliness issues with one of the toilets used by people that lived here.

The provider had corrected these issues by the second day of our visit. However the service's own internal checks had not identified any of these issues, or the potential consequences they could have on the people that lived here.

People told us that they felt staff treated them with dignity and respect. One person said, "Yes, I think they do respect me." Relatives felt their family members were treated with respect. During our inspection we saw that when people were given personal care this was done in private, in their bedrooms with the door closed. We also heard staff call people by preferred names. When we looked in people's care plans we saw that this was their preferred name.

People said they felt safe living at the home. Relatives said they felt their family members were kept safe. A relative told us, "Yes I do feel people are safe here. I am comfortable in the knowledge that my family member is here and safe."

Relatives told us they had been involved in talking about their family member's needs and the risks that could affect them. One relative said, "Staff involved me and my family member in the risk assessments." Each person's care file had a number of risk assessments completed. The assessments detailed what the activity was and the associated risk. They also covered who could be harmed and guidance for staff to take. Examples of the risk assessments seen included risks around the home; skin integrity; falls and fire. Where new risks had been identified, such as a change in a person health, additional assessments had been completed. This showed us that risks to some people were identified and managed in a safe way.

At our last inspection in February 2014 we identified an issue with the levels of staffing. This was because during our visit the number of staff had not matched the minimum levels that the provider said was required to meet people's needs. At this visit we asked people and their relatives if they felt there were enough staff. We had a mixed response. One person told us, "I think we have just about enough staff. They come and spend time talking to me during the day and we have a laugh. I do have to wait for them to come sometimes when they are really busy." A relative told us, "I think places like this could always do with more staff, but I think it's OK at the moment." Another relative told us, "There seem to be enough staff now. It is better than it was earlier in the year. There are a lot more staff on now and no use of agency as far as I am aware." However some people told us that they felt at night and at weekends they had to wait longer to receive care than they did during the week. We looked at the staffing rotas and saw that the number of staff identified to meet people's needs were in place. The Matron explained how they had looked at the needs of the people that lived here and matched the staff to those needs. They told us that with the current number of people they felt they had enough staff, but if more people moved into the home they would need to look at recruiting more staff. During our observations we saw that people had their needs met. This included during the early evening.

To enable them to meet the needs of the people who lived here, staff had completed training in a number of areas. For example in the sample of records we looked at we saw since January 2014 staff had completed training in food hygiene, nutrition and hydration, health and safety, and safeguarding vulnerable adults. The service followed safe

recruitment practices when they employed new staff. The provider had checked that people had no record of offences that could affect their suitability to work with vulnerable adults.

Findings from the focused inspection of 12 and 25 November 2014

People were still not protected from the risk associated with unsafe management of medicines. The registered person did not have appropriate arrangements in place for the safe administration of medicines.

Medicines were still not being kept safely at all times. The key to the medicine storage room was kept in an unlocked drawer in another room. The area that housed this unlocked drawer was not always manned and the room was not locked when it was empty. There was a risk that an unauthorised person would then be able to get the keys to the medicines room, and then access people's medicines.

Appropriate arrangements were not in place in relation to the recording of medicine use. Several records were blank on the medicine administration record (MAR) charts where we should see initials of the person giving medicines or a code to indicate the reason they were not given. There were some instances where the actual amount of medicine administered when a variable dose was prescribed was not recorded on the MAR chart. The policy of the home was to ensure the correct dosage was checked by two people for accuracy. There were times that this didn't happen. The records that related to medicines were not accurate and did not give a true picture of people's medicine history.

Medicines were not disposed of safely. Records were not maintained of medicines that were to be thrown away. This meant that an audit of the used medicine would not be possible as staff would not know if a medicine had been disposed of.

Medicines that were needed regularly did not always have reminder dates recorded on the MAR charts. There was a risk that the ordering of new medication could be missed. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The service had not met the requirements of the warning notice that had been issued, or the action plan they submitted to us. CQC is currently reviewing its enforcement options in relation to the continuing breaches described.

People had their medicines given to them by the nurse in a safe and caring manner. Staff did not leave medicines with people to take in their own time and we did not see any medication left unattended. Medicine that required careful monitoring and frequent changes were managed appropriately.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2014 we raised some concerns over wound care management. People who had pressure sores had not been turned at the required frequency to reduce the risk of the ulcer getting worse and not improving.

During this visit there was one person with a pressure sore. The pressure sore had been recorded and photographed, however it had not been graded and there were no wound measurements recorded on the wound assessment chart. The person had also not been assessed by a tissue viability nurse (TVN). This meant that the staff were unclear how serious the wound was, and if the person was receiving appropriate care to deal with the severity of the wound. We noted that the wound was covered and clean dressings were in place in accordance with the wound care plan.

A waterlow chart had been completed for this person. This is a tool used to identify the risk a person might have of developing pressure sores. The chart indicated the person was at high risk. There was not a complete record to show that the person had received appropriate care, or if their condition was getting better or worse.

The person was nursed on a specialist bed with a pressure relieving mattress. The setting on the mattress did not match the guidance given for the weight of the person. We were informed by staff that this finding may be due to an electricity power failure that took place earlier in the day. We saw the power cut take place in the morning, and the pressure mattress setting was checked by us in the afternoon. This showed no one had corrected the setting after the power cut. This would mean the person was lying on a mattress not set to the correct pressure to minimise the risk of their sore developing further. The staff had received training in setting the pressure mattress and a check had been completed by the provider on pressure mattress settings in June 2014. The incorrect setting on the pressure mattress showed the service was still not effective at ensuring the mattress was providing effective support to the person who was using it.

The provider did not have an effective system in place for ensuring the safety and welfare of people. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt comfortable discussing their health needs with staff. One person told us they did not feel well. Later in the day they told us, "Staff often come by and ask if I am alright. I didn't feel so well this morning and staff made sure I felt better. They always do that, it's not just because you were here."

A person told us, "Staff encourage me to walk up and down the corridor and use my frame as this helps me keep mobile." During the day we saw that the person did these exercises. This showed us that staff had involved this person in their health care in a way that they understood.

Some people had received appropriate treatment when their health needs changed. Health care professionals had regularly visited the service when this happened. People told us they were happy with the health care support they received. A relative told us, "Oh yes, we have a chiropodist and optician, I think they come and visit every so often. The dentist, GP and nurses visit as well." Staff recorded in care plans when people had been unwell, and that health care professionals had visited to see the people. We saw two examples where people who had been unwell had been visited by the GP to monitor their health. In both of these examples the GP had visited three times over a week and a half period until each person was well again. The matron explained that they held daily handover meetings with the staff to discuss people's day to day health needs. These discussed what was happening within the home and how the people who lived there were. This ensured that staff that came onto shift would know if there had been any changes in a person's needs and what action was required from them.

We asked people if they felt involved in discussions around changes in their health or support needs. A person told us "When I had a fall the staff sat down with me and talked about what I could do to stop it happening again. They encouraged me to use my walking frame." The person was also able to tell us about the medicines they took and what the benefit was for them. The relatives we spoke with were also complimentary about their involvement in the monitoring of their family member's health.

People and their relatives told us that they had been involved in the planning and review of the care given. A person said, "They know what I like and don't like, they are good at remembering this." A relative told us, "I think they understand and meet my family member's needs. The staff have taken a lot of time to talk to me and put things into

Is the service effective?

place as a result of what I have said." Care plans also showed that reviews of people's care needs regularly took place with them, and where appropriate their family members and health care professionals.

People told us that they thought staff had the skills and training to be able to meet their needs. Staff were able to describe to us how they met or understood people's individual needs or preferences, for example favourite foods, medical conditions and specific care that people needed. During our observations we saw that staff provided care as detailed in people's care plans. Staff told us that they had received good training. Staff records showed that training had recently been given on topics such as infection control, dementia awareness, health and safety and prevention of falls. This showed us that staff had received training to enable them to meet the needs of the people that lived here.

Staff told us they had regular one to one meetings with their line manager and felt supported; however the provider and matron were unable to locate the records of these formal one to one meetings. Although staff told us they felt supported, these meetings were not documented, and this meant that any actions or issues discussed may not be carried forward and reviewed. The matron said they were in the process of setting up the supervisions and appraisals for staff for the remainder of the year. Their plan stated they would begin the one to one meetings with staff in August 2014.

People said that they had enough to eat and drink during the day and night. One person told us, "I always have water and juice in my room. I never feel hungry at night, but I can get up and have a cup of tea if I want." They went on to say, "There is always a good choice of food such as different meats, and vegetables." A relative told us, "The food here is very good. Anytime I visit I can have lunch." We asked about the amount of food and drink on offer and they said, "There are always drinks being handed out and staff do come and help those that can't drink or eat on their own."

Where a need for a specialist diet had been identified this was met. For example some people were on a soft or pureed diet due to problems with swallowing. The pureed food was presented on the plate in separate portions so that the person was able to taste each individual item that made up the meal. A relative described how their family member had a special diet to meet their swallowing problems. They also told us that staff kept a track of how much their family member was drinking. During our observations we saw staff update fluid charts throughout the day where a need had been identified. This ensured that people's fluid intake was monitored so staff knew they were getting enough to drink. Where support was needed we saw that staff took time to help people eat. Staff were also seen to talk to people while they were eating. Relatives were able to support their family members to eat if they wished. People were able to eat their meals in a relaxed and unhurried manner.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives if they felt staff treated them with dignity and respect. All of the people we spoke with said, "Yes." People felt that all the staff were kind and looked after them well. One person told us, "Yes I think they do respect me. I have a good relationship with the staff" A relative told us, "Staff are very polite." We saw that overall staff treated people with dignity and respect. Staff called people by their preferred names, and when personal care was given this was done in private. They explained to people when they were going to do something with them, such as moving them with a hoist. At each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

However during our observations we saw three incidents where staff acted in a way that showed that some improvements could be made around respecting people. For example after lunch a person was organising paper napkins on a small table by their chair. A staff member who was clearing away the lunchtime items saw the napkins and scooped them up to throw away without asking the person first. The person immediately indicated to staff that they were not happy, so the staff member apologised and replaced the napkins. We also observed two instances where staff and the provider showed a lack of respect for a person's bedroom by using it to make phone calls and have a break in. A number of issues around the environment showed that people's rights to privacy could be compromised. People did not have the facility to lock their bedroom or that of some bathrooms and toilets. These examples showed that not all staff understood how their actions or the environment could show a lack of respect and dignity to the people who lived here.

We received some comments that on occasion people found it hard to understand what staff were saying. They told us that staff sometimes spoke too quickly, or talked as they walked away. This made it hard for people who had hearing difficulties. During our observations we did not see this happen. This was fed back to the provider, staff needed to be aware of people's communication needs when discussing their care and support as miscommunication could increase the risk of harm.

We asked people if they felt the staff were caring. Everyone was very positive about their experiences. Each person said staff were kind and looked after them well. One person told us, "All the staff are very kind to me." A relative said, "Oh yes, the care here is good. The staff have asked me about my family member's likes and dislikes to get to know him, as he can't do this for himself." Another relative told us, "Yes they are definitely caring here; I have no issue at all about that." A health care professional told us, "Every time I have been in, the residents always seem very happy, there is lots of interaction with the staff and they spend time talking with the residents." They went on to say, "The staff I have seen are very caring with the residents." A staff member told us, "I like the residents to be happy, if they're happy, I'm happy."

We saw appropriate care was given to meet people's needs. All the people we spoke with said their needs were met by staff. Staff interaction with people was very positive, for example when one person became agitated a staff member sat with them and asked them what was wrong and kept them company. They held hands with them and spent time calming them down. The staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests. The details we saw in the care plans highlighted people's personal preferences, so that staff would know what people wanted from them. Staff knew people's religious, personal and social needs and preferences from reading their care plans. When we spoke to people about their preferences and then looked at the records, we saw that these preferences had been recorded.

The people and relatives, where appropriate, said they were happy and felt they were involved in the care that was provided. One person told us "Yes, I think I am involved in my care." A relative told us, "Yes, so far we have been involved. They have asked us many different things about my family member and we have agreed what they will do." Another relative said, "I have definitely been involved in making decisions about my family member's care."

People were actively involved in making decisions about their care. Over the course of the day we saw numerous examples where staff asked people questions about their preferences and choice of how and when their care was given. Staff did not rush people for a response, nor did they make the choice for the person.

We asked people if they had information given to them about their care and support. They responded positively about being kept up to date about their care needs. One person we spoke with was able to tell us about their

Requires Improvement

Is the service caring?

condition and what their medication was for, as well as all the appointments they had been to, to help them get better. This showed that staff had explained to the person in a way they could understand and remember.

People were given the privacy they needed. Staff knocked on doors and waited for a response before they entered. Staff also told us that they would close curtains in people's rooms when they supported them. Relatives told us that they could meet with their relatives in private.

People had equipment and choices provided to enable them to be as independent as possible. One person said, "I'm very happy here. I choose my clothes in the morning." A relative told us "I have asked the staff to do some things for my family member, but the staff have explained to me that they have to do what my family member wants to do, to encourage them to be independent."

People could be confident that their personal details were protected by staff. There was a confidentiality policy. Care plans and other confidential information about people were kept in the matron's office. This ensured that people such as visitors and other residents could not gain access to people's private information.

Requires Improvement

Is the service responsive?

Our findings

People told us that there were some activities on offer, but these did not happen every day. One person told us, "We have a singer that comes in quite regularly, so we can sing along with them." However another person said they were, "Bored, bored, bored." A relative told us, "They do have activities here, but my family member is past all that now due to their condition. Staff do sit and talk with them though." Another relative told us "My family member gets to go on trips out for tea, and has been to the Epsom playhouse. They had a very good time."

During our two day visit there was little organised activity on offer. Staff spent time talking with people and doing basic exercises with a ball. However the majority of people spent time sitting in the communal areas with the television on, and not watching it. Some people had regular visits from friends and family. During the first day a person returned from a trip out with their relatives. They and their relatives spoke to people as they walked past talking about what they had done. As this was going on people in the room brightened up and started talking to each other. When the person and their relative moved out of the room, the people sat back and stopped talking with each other and returned to staring at the television or just looked around. Although there were some activities on offer by the provider, such as a visiting singer and music, there could be improvements made to give more stimulating and interesting activities to people to meet their individual needs and interests.

At the time of our visit there had been no residents or relatives meetings held at the service. These can be useful because they give people an opportunity to feedback and at the same time see if other people are having the same problems, or to give positive feedback about the service. However at the end of the first day of our inspection, relatives told us that the matron had already been in contact with them and was in the process of setting up a date for a meeting.

People said that they received individualised care. One person said, "I get to read my books and I get to go out for walks with my relative." They went onto say, "I don't mind who gives me personal care but I know I can have a choice if I want." A relative told us, "When my family member fell over staff responded as quickly as they could. Also when my family member had an infection staff got the GP out very quickly." We had mixed views from visiting healthcare professionals about the responsiveness of the service. One told us that, "The staff do a good job. They recognise when there is a problem and then refer the person to us. Their assessments are really good and they keep records up to date for us. It is all perfect for us." However another healthcare professional told us that in the past, issues with people's health had not been identified and acted upon by staff.

During our inspection we saw that people received care and support when they needed it. When a person was unwell we saw that staff involved the person and carried out health checks with them, and gave treatment. They then checked a little later to see if the person felt better. We spoke at length with this person later in the morning and they told us they felt a lot better. A relative told us about how the service had responded to their family member's needs. They told us, "The nurse has spotted things happening with my family member's health. They kept me updated on the action they were taking, to make sure I was happy with what was happening."

We asked people and their relatives if they had been involved in the assessment of their needs. Some told us that they could not remember, while others told us they had been. A relative told us "The only thing I think they could improve on would be for them to type the care plans up so it would be easier to read."

Staff told us they felt the care plans were detailed enough so that they could provide good quality care and know the person as an individual. When we reviewed the care files we noted that the sample we looked at contained a good level of detail about the person and their support needs. For example one gave clear instructions to staff on how best to communicate with that individual, while another recorded that a person could feed themselves with the appropriate equipment. This was in use when we observed the lunch. They also contained information about what people were able to do for themselves and what they may need help with. Information on religious and cultural needs was included in the care plans, as was information such as allergies. The care plans were well organised with an index at the front. This made it easy to retrieve information. Future decisions for people had also been recorded so that staff would know their choices and preferences. Do Not

Requires Improvement

Is the service responsive?

Resuscitate forms were seen in some of the care files we looked at. These had recorded who had been involved in the decision, for example the person, their relative and a GP.

The care plans had been regularly reviewed. This would mean that people's needs were looked at to make sure the service was still meeting those needs. However we did receive feedback from a visiting healthcare professional who said, "The files were difficult to read (as they were all handwritten) and were too general in content." The matron had responded by updating and reviewing the files. This was ongoing at the time of our visit. Another visiting healthcare professional thought the care plans they had seen were of a good standard. They told us, "The staff are very organised. The paperwork I need to see is always ready for me."

People received personalised care in a number of ways. One example seen was where the chef was able to identify each person's food requirements and their preferences. They gave examples of particular foods that individuals did not like and the alternatives that they were offered when this food was on the menu. There were clear records kept that detailed a person's nutritional requirements. Any allergies that had been identified in the care plans had also been carried over to the information that the chef had.

We asked people what they would do if they were unhappy with the service. They all told us they would tell the staff.

One person told us, "I would see the matron and tell her." A relative said, "I would talk to the staff, but I am not aware of any information pack that might tell me how to make a complaint." Another relative told us they had received the information pack and this told them how to make a complaint.

People told us they felt comfortable giving feedback to the staff about their care and that things improved if they raised issues with them. One relative told us, "Yes, without question. They are only too eager to please now." They told us about how the service had improved quite a bit since our last visit in February 2014. No one that we spoke with said they had raised any formal complaints recently. There was a complaints policy in place, which detailed how the service would respond. It also gave details of external agencies that people could complain to such as the Care Quality Commission and Local Government Ombudsman. This information was contained within the residents handbook which the provider told us was given out to people when they joined the service. Not all relatives we spoke with knew it was there. The home kept a complaints log. We saw that a clear record was kept of each complaint that had been received. The service had recorded the investigation into the complaints and identified any trends, patterns and contributory factors. From looking at the records we could see that people had been responded to in good time. There had been no complaints recorded since our last inspection visit.

Inadequate

Is the service well-led?

Our findings

Findings from the comprehensive inspection of 07 and 08 July 2014.

The management did not have effective quality assurance systems in place to check that they provided a good service to the people who lived here. At our previous inspection in February 2014 we identified four concerns with the service in relation to medicines, how people were cared for, numbers of staff and sending reports to CQC when incidents took place. During this inspection two of the four issues had not been fully addressed. The provider had failed to monitor that actions needed to provide a good quality of care were put into place.

We saw examples where the provider had not identified issues within the home that could have an impact on people with mobility issues, or who may be frail and prone to infections. Staff had recorded some issues in a maintenance log, and these had been repaired. However on the first day of our visit there were a number of maintenance and cleanliness issues found, such as radiator covers that were loose or broken and posed a risk to people; a trip hazard due to a damaged carpet in a bedroom of a person with mobility problems; lack of soap and paper towels available in one of the sluice rooms and the cleanliness of one of the toilets used by people that lived here. The provider had corrected these issues by the second day of our visit. However the service's own internal checks had not identified any of these issues, or the potential consequences they could have on the people that lived here.

Not all of the services policies and procedures were up to date or reviewed. There were multiple policies around medicines, and safeguarding. The provider was unable to find a wound care policy for the organisation which would explain how they would care for people with pressure sores. These issues would make it hard for staff to know which were the most current policy and guidance they should follow.

The service had completed some audits to check the quality of the service being provided. For example completion of care records, medicine records, complaints, and health and safety. A monthly quality assurance visit was also completed by a staff member. The last one had been completed in April 2014; two months had gone by with no audit being completed. These visits consisted of an interview with one resident and one member of staff to gain feedback about the service. This was not a representative sample size to gain meaningful feedback from people to show the service was giving a good quality service.

A record of accidents and incidents that had occurred was maintained. The matron was able to tell us about how they would need to look at the reports to see if there were any patterns that would indicate the service needed to make improvements. They said, "For example if someone had begun to have an increase in the frequency of falls, I would need to look into it and make a referral to a falls clinic for the person." However the provider and matron were unable to show us evidence that any analysis of accidents and incidents had taken place since our last visit.

Due to the failure of the provider to effectively monitor the quality of services at the home, and two continued breaches in the regulations from our previous inspection this was a breach in Regulation 10 of the Health and Social Care Act.

We spoke with the provider about the issues we had found during our inspection. They told us, "If people tell me what we need to do, then I will make sure we do it." This was shown during our inspection as where we highlighted issues with maintenance and cleanliness these had been fixed by the next day. A relative told us, "The service is reactive rather than being proactive." This means they respond quickly when they are told, but were not always identifying themselves when they needed to improve.

We asked people if they thought the service was well led. Some people did not know who the provider was as they had never had the opportunity to speak to them. One relative told us, "I can't say anything at all where I haven't been happy with the care staff. So far they have given me everything I and my family member wants." People told us the matron was very visible in the home, and was often seen talking with people and staff. We saw this take place on both days of our inspection. They provided good leadership and direction to staff. This would ensure they had an idea of how people and staff were feeling.

People felt they had some involvement in giving feedback about how well the service was doing. A relative told us, "They ask me questions, or I ask them about things. They are open with me and don't try to hide things." Relatives told us that the matron had been in contact with them

about setting up a formal meeting to enable people to give feedback about what they thought of the service. Feedback surveys had been sent to people for some aspects of the home. These showed that where suggestions had been made, for example in relation to menus, these had been acted upon.

People felt that staff were motivated and generally supported by the management. A relative told us, "The care staff here are very friendly." Another said, "Staff never appear grumpy, they always smile. I don't see them sitting around doing nothing, they are always busy with people." However some people felt that the provider was not doing enough to support the staff, which had a knock on effect on the quality of the service. For example they told us, "Staff always appear to be rushing around and we have to wait sometimes."

Firtree House had a philosophy of care statement. This was contained within the resident's handbook. It detailed what people could expect from the service such as privacy and dignity, personal choice, and promoting independence. During our observations we saw staff worked in a manner that followed the philosophy of care set out by the provider.

Staff had a clear understanding of their responsibility around reporting poor practice. There was a whistleblowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. This gave clear guidance for staff to follow, including who to report concerns to outside of the provider. The policy had been signed by staff to say they had read and understood it.

The home did not have a registered manager at the time of our visit. They had left the service one week prior to our inspection. Their replacement, the matron had been in post for two weeks. They were aware of the issues the service had had in the past, and were working on a plan to carry on improving the service. The matron was aware of the key challenges of the service, and that they would need to register with the CQC.

At our last inspection we had identified issues where the service had not notified the CQC of reportable incidents, such as when people died. The matron had a clear understanding of what needed to be reported and this was shown by recent notifications that we had received.

Findings from the focused inspection of 12 and 25 November 2014

The provider still did not operate an effective quality assurance system that protected people against the risks of inappropriate or unsafe care. The provider's quality monitoring processes were still not effective in identifying risks to people. We found that several rooms, including the sluice room and a communal bathroom on the ground floor, were not locked and were therefore accessible to people living at the home who may be confused. Both these rooms contained hazardous substances including bleach and disinfectant. The toilet in the communal bathroom on the ground floor had no seat, which presented an additional hazard.

The provider was unable to show us that they carried out checks or audits on any aspect of service delivery to ensure people received a good standard of care. The manager advised that quality monitoring checks had still not been implemented since our last inspection. This meant that key areas of service delivery, health and safety, infection control, care documentation and staff training were not checked to ensure that people received safe care.

The manager had recently implemented a system to audit practice around medicine. However we did not see that the audits were used to implement learning from the findings. The provider did not have effective governance systems in place to ensure medicines were managed and handled safely.

During a meeting held by the provider on 20/08/2014 relatives had been able to give their views about the care their family members received. The minutes of the meeting showed that relatives raised a number of concerns about the care provided. The provider was unable to show us that they had acted upon these concerns or implemented changes to address them.

The policies had been updated by the provider, matron and administrator. The policies were located in the office. There was a sheet at the front of the policy folder for staff to sign stating that they had read and understood the policies, to date no-one had signed for them, upon speaking to the matron, she stated that staff had not had the opportunity to read through them. Staff would not then know if they were providing care and support in a way that met those policies.

Inadequate

Is the service well-led?

This was a continued breach in Regulation 10 of the Health and Social Care Act. The service had not met the requirements of the warning notice that had been issued, or the action plan they submitted to us. CQC is currently reviewing its enforcement options in relation to the continuing breaches described.

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 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Findings from the comprehensive inspection of 07 and 08 July 2014.** The registered person had not taken proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, as the practices did not reflect published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment **Regulation 9 (1)(b)(iii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Findings from the comprehensive inspection of 07 and 08 July 2014.** The registered person did not have suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse. **Regulation 11(1)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Findings from the comprehensive inspection of 07 and 08 July 2014.** The registered person did not have suitable arrangements in place for obtaining, and acting in

This section is primarily information for the provider

Action we have told the provider to take

accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

Regulation 18(1)(b)