Hampshire County Council

Forest Court Nursing Home

Inspection report

Forest Way
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Tel: 02380664770

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18 August 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Forest Court Nursing Home is a purpose built nursing home and reablement unit, accommodating up to 80 older persons, including people who are living with dementia.

The inspection was unannounced and was carried out on 17 and 18 August 2016.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People told us they felt safe living in the home and that care was delivered in a safe manner. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by sufficient staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People and their families were encouraged to express their views and be involved in making decisions about their care and support.

People were supported to have enough to eat and drink. Mealtimes were relaxed and staff supported people in a patient and friendly manner.

There was a programme of activities for mental and social stimulation and staff were working on extending this for people who were cared for in bed.

The service was responsive to people's needs and any concerns they had. Care and treatment plans were personalised and focused on individual needs and preferences.

People were encouraged to provide feedback on the service provided both informally and through an annual questionnaire.

The registered manager demonstrated an open and inclusive style of leadership. Staff understood their roles and responsibilities and there were clear lines of accountability within the service.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

The service supported people and their families to express their

views and be involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

The service was responsive to people's needs and any concerns they had.

Care and treatment plans were personalised and focused on individual needs and preferences.

There were a range of activities available and staff were working on extending this for people who were cared for in bed.

The registered manager had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager demonstrated an open and inclusive style of leadership. Staff understood their roles and responsibilities and there were clear lines of accountability within the service.

People, their families, health professionals and staff had opportunities to feedback their views about the home and quality of the service being provided.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare.

Forest Court 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and was carried out on 17 and 18 August 2016 by one inspector accompanied by a specialist advisor and an expert by experience. The specialist advisor had clinical and practical experience and knowledge of best practice relating to the care of older people and those living with dementia. The expert by experience had personal experience of working in and caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people using the service and two relatives. We observed care and support being delivered in communal areas of the home to help us understand the experience of people who could not talk with us. We spoke with ten members of the nursing and care staff, the two deputy managers and the registered manager.

We looked at a range of documents and written records including 10 people's care records, risk assessments and medicine charts, staff recruitment, rotas and training records. We also looked at information regarding the arrangements for managing complaints and monitoring the quality of the service provided within the home. We received feedback about the service from two community care professionals.

The home was last inspected on 24 September 2014 when no issues were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home and that care was delivered in a safe manner. For example, people said they felt safe when staff assisted them to mobilise using a hoist. One person said they felt safe because "There's always people around".

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were aware of the safeguarding and whistleblowing policies and procedures that were in place and confident around using them if required. Whistleblowing is a policy protecting staff if they need to report concerns to other agencies in the event of the organisation not taking appropriate action. Staff also had knowledge of the policy and procedure for reporting accidents or incidents. A nurse told us that once an incident form was completed, a member of the management team would discuss the information with them to see if there was anything that needed to be done as a result.

Staff respected and promoted people's independence, while remaining aware of their safety. For example, a person told us they were able to move freely around the home using a walking frame and we observed people doing this. Risks to people had been identified, assessed and actions had been taken to minimise them. Assessments were in place to help prevent people falling or developing pressure sores. This information was recorded in each person's care records and updated regularly with any changes to the level of risk. Daily care records showed staff supported people in line with the risk assessments, for example regular repositioning was undertaken to prevent pressure damage to people's skin.

People were supported by sufficient staff with the right skills and knowledge to meet their assessed needs. Staffing levels were kept under review and additional staff could be used if people's needs changed. People told us that staff were available when they needed care and support. Staff confirmed there were enough staff on duty and were able to respond to people quickly. The service had introduced a new assistant practitioner (AP) role. The new role was performed by senior members of the care staff team who had level three diplomas or equivalent qualifications in health and social care.

One relative told us "They do use agency but try to use regular agency". They said "The AP role is helping. The APs I've met are very good, chatty and friendly. It has given the nurses more time". A person said staff were "On the whole good". They confirmed staff were polite and respectful "but they are variable in their abilities".

A community care professional told us there was a shortage of nursing staff nationally and the home used a lot of agency nurses to fill the gaps. They felt this could affect continuity of care for people and made it more difficult for the GP to get clear information as the agency staff did not know the people well. They added that at present there were a lot of long term agency nurses which made it easier for continuity of care. We saw a photo board in the reception area included photos of regular agency staff as well as the permanent staff.

The provider was recruiting for more staff and using regular agency staff as much as possible to cover vacant

posts, in order to maintain continuity of care for people. On the first day of the inspection the service was two care staff short on one of the units, due to sickness at short notice. Care staff told us they were able to cope with this and said the nurse "Is very good and will help". They also said "If there is any problem with staffing they can talk to the managers who will try to get people at short notice". A nurse told us that, while the home could sometimes be short of staff, this was never a big problem as the home worked as one unit and staff would come from other units to help out.

Staff rotas were planned in advance and other records showed at a glance the daily allocation of staff to provide cover across all units. Any short notice staffing issues would also be identified during the handover meetings so that staff deployment could be adjusted. There was a registered manager and two deputy managers, one clinical and the other non-clinical. One nurse oversaw two units supported by two assistant practitioners and four care staff.

The provider had a system in place to assess the suitability and character of staff before they commenced employment. Records included interview notes and previous employment references. Staff were required to undergo a Disclosure and Barring Service (DBS) check. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk. The system of checks included agency staff who worked at the service. Records were on file showing that checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Regular fire alarm tests and drills were carried out and staff attended relevant training. Equipment was checked and serviced at regular intervals.

People's medicines were managed so that they received them safely. There were robust procedures and documentation in place and staff demonstrated clear knowledge and understanding of the processes. Nurses and senior care staff told us they received annual medicines training which included competency assessments.

The medicines room was clean and tidy, cool and fit for purpose. Fridge and room temperatures were each recorded twice daily. Medicines trolleys were clean and secured to the wall when not in use. The dates were recorded when packets and bottles of medicines were opened. Medicines administration records (MAR) contained no gaps and were clear, legible and organised. The medicines folder contained a list of signatures of staff authorised to give out medicines.

A nurse was responsible for ordering medicines on each unit and a comprehensive system was in place for this. Medicines disposal was carried out as required and included a medicines disposal book for recording.

The controlled drugs (CD) record book was clear and legible. Entries were double signed and correct numbers were recorded in the total column. Records showed CD's were given as prescribed. CD daily check charts were in place and being used appropriately.

The medicines folder contained clear instructions as to what, when and how, homely remedies could be given. (Homely remedies are medicines which the public can buy to treat minor illnesses like headaches and colds). Records of covert medicines had been agreed and signed by the GP and the person's family were aware. Mental capacity assessments had been completed to show covert administration of the medicine was in the person's best interest.

Pain charts were in place and these were used at each medicines round, to support staff to know if a person's pain was improving or getting worse. Charts for medicines taken on an "as required basis" (PRN) were in place in all the relevant files and utilised for those people requiring them. There were separate protocols for each PRN medicine including clear instruction as to what, when and why it could be given.

The registered manager was aware of their responsibilities in relation to infection control. An annual infection control statement was written and the registered manager was aware of what needed to be reported. This statement was produced in line with Department of Health guidance on best practice in relation to infection prevention and control (IPC). The registered manager carried out a bi-monthly IPC audit as part of the provider's quality assurance procedures. The registered manager also carried out random audits of the sluice rooms to check on cleanliness and tidiness. Cleaning schedules were in place on each unit and records kept to show these were adhered to.

Protective clothing was available and in use by staff. The training record showed that staff received training in infection prevention and control. We observed a care worker assisting a person to wash and dry their hands. The care worker wiped over the person's walking frame with cleansing wipes. A relative said "I have no complaints regarding the cleanliness here". A member of staff told us that when they came to work at the home the "First impression I got was how clean it is".

Good

Is the service effective?

Our findings

A community care professional told us they and the staff team at Forest Court had regular meetings in relation to the reablement service. They said "We work as a very close knit team and support each other in getting the best for each individual". They told us about one person "who was bed bound and (staff) were able to get this lady to be able to transfer with a (walking frame) and a couple of steps. This was a great moment for the individual and their family". Another community care professional said the care staff overall provided good care and attended regular training updates facilitated by the provider.

Staff were provided with an induction, further training and relevant qualifications to support them in meeting people's needs. The provider's induction programme for new staff involved eight days of essential training during the first four weeks, complemented by shadowing experienced staff to help ensure that the training could be applied in practice. A system was in place to track the training that each member of staff attended. Staff confirmed they had training and on-going updates in subjects including moving and repositioning, infection prevention and control, safeguarding, emergency aid, fire safety, dementia awareness, Mental Capacity Act (MCA) 2005, and nutritional risk assessment.

A member of staff told us the provider's "Training is very good and they will support you to do something (training) if you want". A nurse told us the training they received was "Really good, there is lots of it". The provider's Practice Development Nurses (PDN) attended the home regularly to deliver training sessions and were currently helping nurses with the process of revalidation with the Nursing and Midwifery Council (NMC). Another nurse told us their recent training included resuscitation and choking, safeguarding, and nutrition.

One of the assistant practitioner (AP) staff told us about their current learning. They had received basic wound dressing training and was now doing that on the unit. They had also completed medicines competency assessment and could now do medicines rounds excluding CD's and injections. They clearly enjoyed their role, telling us "It's excellent. I'm busy and I have responsibilities". They said that the care staff, AP and nursing staff all functioned well together.

Staff had received training in relation to caring for people living with dementia, some of who may become distressed and whose behaviour may sometimes present a challenge to others. A nurse explained how in the first instance behaviour charts and de-escalation techniques were used along with a urine screen for a possible urinary tract infection. Staff would try to establish what was going on and why. If after a month there was no change staff would discuss the matter with a GP who would either give further advice or refer the person to the community mental health team. The use of medicines was always a last resort. The nurse told us that recently several people had medicines reduced or stopped due to a reduction in their presenting behaviours. The nurse was articulate and enthusiastic and demonstrated experience and skill with dealing with such presentations with empathy and confidence.

Supervision records were on file. The registered manager said that ideally supervisions would take place every eight to ten weeks. They had a system in place to monitor when supervisions were not taking place to the desired frequency. Staff confirmed they found supervision useful. In addition to individual supervision,

group staff supervisions were held to discuss topics such as falls and for joint learning. Regular agency staff were also invited to group supervisions. The registered manager told us the supervision agenda now included nurses providing reflective pieces of work to support their applications for revalidation with the NMC. There was a system of annual appraisal of individual staff performance and development, with a focus on goals and behaviours.

Staff had received training in the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff showed an understanding of the principles of the MCA in relation to people they were supporting. Before providing care, they sought consent from people and gave them time to respond. Staff told us they would assume a person had capacity and respect their choices. They spoke of the importance of treating each person as an individual. They would report any concerns about a person's capacity to make particular decisions to a senior member of staff who would arrange for a mental capacity assessment. The two deputy managers spoke clearly and confidently about the MCA and people's rights.

A community care professional told us the majority of people had complex needs including dementia and mental capacity assessments were carried out to establish whether they were able to consent to the care and support provided. Another community care professional said "Capacity is always looked at as everyone is able to make some decisions and if they cannot, support is given to the individual and their families. We do the mental capacity assessment and best interest (decision) as a team".

The provider had a mental capacity assessment tool that was used to evidence the steps taken to support people to be involved in their care; and to demonstrate the rationale when decisions were to be made by others in the person's best interests.

Where people had relatives or other representatives with power of attorney for particular aspects of their care this was documented. A relative told us "The carers ask; they don't just do things". Some people had signed to indicate their involvement and/or consent to their care plans.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had identified a number of people who they believed were being deprived of their liberty, and had applied for appropriate authorisation from the local authority.

People's support plans included nutritional assessments and details of their dietary requirements and support needs. A risk assessment tool was used to help identify anyone who might be at risk of malnutrition and specific care plans were in place to minimise this risk. Food and fluid charts were used to monitor people's intake during periods of potential risk.

Although the monitoring charts were in place, these did not always document how much fluid people should be aiming towards each day. A nurse told us "I think it is common knowledge. People should aim to have 1.5-2 litres per day". They explained that if an individual had only had a minimal amount of fluid that it was handed over at the end of each shift. There was also the nutritionist staff on the units to ensure there was one dedicated member of staff who could give 100% attention to those experiencing difficulties with

nutrition and fluids. The nutritionist care staff were a small group of staff recently employed with the specific role of supporting people at mealtimes and encouraging fluid intake.

During the day we observed staff making sure people had drinks and supporting them to drink if needed. A member of staff went round each unit asking people about their choices for lunch and supper. Two main choices were offered and alternatives were available if asked for. During this time the member of staff also encouraged and supported people's fluid intake.

People were complimentary about the food and told us they had enough to eat. Their comments included "Nice, we get variety"; "Yes, I'm always full"; and "Lunch was lovely, fish in sauce, lovely. The food is very good". A community care professional told us "Meals are balanced and (people) have choices and if they want something that is not on the menu (staff) do try to get it for the individual. All residents are given choices and are encouraged to be able to do some things themselves, even if it is just to drink from a cup".

We observed lunch being served. People were supported to eat where they chose, either in the dining areas or in their own rooms. During the lunch period there were sufficient staff to help with assisting people to eat and there was an effective use of teamwork, which meant people received their meals and any support they required in a way that was both timely and unhurried. Staff were patient and kind in their approach and explained to people what was on their plate. Different coloured plates were available and used. This is helpful to people living with dementia, who may find it difficult to differentiate objects. Specialist cutlery was available and plate guards were also used to support people to eat independently. Staff demonstrated knowledge of which people were on soft, fortified, or other special diets and records also contained this information.

People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, occupational therapists (OT), podiatry, dentists and opticians. Staff followed the advice of community care professionals. A person had laminated sheets of physiotherapy exercises on their wardrobe door. They told us "The care staff do those with me before I get up, it's only just started. The OT set them up for me". A relative told us "If (the person) has a hospital appointment they send an escort if I can't go and they send packed food, which is thoughtful and good."

Good

Is the service caring?

Our findings

Staff developed positive caring relationships with people. One person told us "I get on with them. I've got a good relationship with them"; and "They are always helpful". Another person said "It's a lovely atmosphere, the care is wonderful". They said Staff were "Very caring, super, very good. Nothing is too much trouble". A person using the respite service said "I've been here before, it's excellent. I know a lot of the staff; it's nice to see their faces. They remember me and I remember them". A relative remarked "All the staff are super. They like caring and know what's involved".

A community care professional told us "The staff are very supportive and friendly"; and said "At times we have people who don't want to leave as they have enjoyed the experience at Forest Court". Another community care professional told us the care, nursing and adminstrative staff were kind and caring towards people and their families.

There was a welcoming atmosphere in the home and we observed respectful and compassionate interactions initiated by staff. A person started to get upset and was crying about their spouse. A care worker came in straight away and reassured the person, telling them their partner would be visiting later as usual. There was a friendly and caring rapport, with the person calling the care worker by their first name. A member of the kitchen staff informed a care assistant that a person in the lounge was feeling chilly. The care assistant approached the person, asked them if they were cold then went and got them a blanket.

We observed all staff were out on the units unless writing notes or on the phone. This demonstrated a focus on supporting and caring for people. A member of staff told us "Communication is very good" among the staff and management team. They enjoyed working at the home and getting to know the people who lived there "As individuals, showing them they matter". Knowing the people helped them to monitor their wellbeing "If their needs or moods change". They said it was important for people "To feel happy, secure and heard" and added "It's our workplace but it's their home".

During the morning staff came into one of the lounges and asked if people wanted to go into the garden. This received a positive response from a number of people who were then supported to go outside. It was a warm day and tables with umbrellas were set up in the garden and people had drinks with them. Staff maintained a presence and chatted with people while they were there.

We observed a person walking in the corridor and being greeted by a member of staff. Both knew each other by name. A member of staff told us how they supported a person who was unable to see or hear and said "She will know who you are by touching your arm". The member of staff attended to a person who called for assistance and made them comfortable. We saw people's families had sent in greetings cards thanking the staff for the care they provided. Relaxing music was played in the reception area, where some people liked to sit.

The service supported people to express their views and be involved in making decisions about their care and support. Each person had a member of staff assigned to them as a key worker. Key working is a system

where a member of care staff takes special responsibility for supporting and enabling a person. The aim of this system is to maximise the involvement and help to build relationships between people using the service, their families and staff. People were also involved in the running of the service through regular residents and relatives meetings that were recorded and shared. Annual care management reviews were held for each individual.

A relative said "I get phone calls and am kept up to date". They also told us "I go to the family meetings and have my say"; and "They record the minutes and bring them to the next meeting". We asked if things that are raised get done. "They seem to, generally, yes. I know things don't get done overnight".

People's care and support plans contained sections on their life histories. Staff asked people, or those close to them if appropriate, about what was important to them. For example, people's preferred names were recorded and used by staff. The home had open visiting times and visitors were encouraged to actively participate within the home by having lunch and assisting their relatives with food and drink, reading, talking, and joining in with activities.

People's end of life care wishes and any advance decisions were also discussed and documented in their care plans. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate.

People received support in a manner that was mindful of their dignity and respect. The care staff were kind and courteous and we observed they knocked on doors before entering people's rooms. People received personal care in the privacy of their bedrooms. Staff gave examples of respecting people's privacy and dignity, for example keeping a person covered as much as possible while assisting them to wash. Care plans and associated records were written in a way that promoted dignity and respect. A relative told us "I've never come across any unwelcome comments. Staff are polite and always speak nicely to (the person)".

Good

Is the service responsive?

Our findings

The majority of comments we received from people and their relatives indicated that the service responded well overall to individual needs and concerns. A community care professional told us "The staff at Forest Court are very quick to identify if there is a health problem. They do all the observations and if needed a GP is called and this is dealt with very quickly".

A personalised approach to responding to people's needs was evident in the service. Before people moved into the home they and their families or representatives participated in an assessment of their needs to ensure the service was suitable for them. Following this initial assessment, personalised care plans were developed that provided guidance about how each person would like to receive their care and support, including their preferred routines of care and how they communicated their needs.

Care plans on the whole were informative and person centred. We did note there was sometimes a lack of detail in aspects of some people's care plans, such as guidance in relation to behavioural / communication support and management of a health condition, which would support staff in providing care. Care plans had not always been updated promptly when people's needs changed. Staff demonstrated knowledge and understanding of people's care and support needs and the management team monitored the care people received. The provider was in the process of reviewing the format of care and support planning.

Other records were well completed and assisted staff in monitoring people's health and wellbeing. Turning and repositioning charts were in place and those we saw were all accurate and up to date and time. One person often declined to be repositioned. Staff respected their decision but would return later to offer support. This was clearly documented and the action taken recorded.

A community care professional told us the service was working with them to empower the nurses and care staff to reduce the GP call out rate by managing things internally first, using advice from the community nurse and other services like the diabetic community team or tissue viability nurses. Nursing staff were fluent on wound care processes and told us they utilised the provider's online resources and the expertise of the community tissue viability nurse. Each person had a tissue viability care plan and any issues were also discussed at the daily nurses meeting. A nurse told us the service had a positive relationship with the GP surgery, which was also active in supporting end of life care.

People were treated responsively when they had particular health conditions, for example, with the use of specific plans for people who had urinary tract infections. The plans described additional care people required to address the specific acute health care need.

A staff handover took place on the units both at 07:50 and again at 10 am. The rationale for this was to improve communication and to focus on people's needs and the tasks of the shifts. We observed a handover on one unit. A nurse introduced the meeting but it was predominately led by the care staff. There was a lot of informative discussion that was also to the point and factual, such as the management of people's healthcare needs, turning and repositioning, and people's moods and behaviours. The handover

also included discussion around food and fluids, which the nutritionist was able to advise on and take on the task for completing. At the end of the handover a discussion took place as to which people still required assistance with their morning routines and reallocations were made. This helped to ensure that people's needs were met in a responsive manner. The handover process was well facilitated and effectively implemented.

The service included a nine bed reablement unit providing up to six weeks assessment and support for people. A social care manager and an occupational therapist were based at the home for part of each week. Weekly multi-disciplinary team meetings were held, including the occupational therapist, physiotherapist and care staff, at which goals were set and monitored, for example to support people's mobility improving.

The service had been unable to recruit a lead nurse for the unit, which was currently overseen by an assistant practitioner. Nursing staff were available within the home to provide support if required. The assistant practitioner spoke enthusiastically and with knowledge and understanding of the service being provided. They and another member of staff working on the reablement unit described their jobs as "fast paced and rewarding". A member of the care staff told us "The assistant practitioners help on the floor when their work is done". They added that this gave care staff "A lot more time for one to one interactions". They said they felt all staff on the unit "Work well as a team".

People had call bells within their reach and told us staff generally responded in a timely way when they used it. One person remarked "They're usually pretty good at coming". The call system was relayed to pagers that were carried by care staff and emitted an audible alarm when a person called for assistance. A call log was held within a computer system and the response times could be monitored. We observed a person called for assistance and care staff responded swiftly to support them. The person and the member of staff chatted in a familiar and friendly manner and the person was also encouraged to drink.

We asked people if there were things going on for them to join in if they wanted. One person told us "I went on a boat trip the other day. I really enjoyed it. We have bingo and things like that. Staff (activity co-ordinator) comes and asks me if I want to join in". They said "Sometimes I go out (in the garden). We had a fete the other weekend and I enjoyed that".

A relative told us "The latest activity co-ordinator is a very good artist and is getting people to paint which (the person) particularly likes to do. She (activity co-ordinator) has a good imagination and gets people doing things". They confirmed a range of activities took place and commented "They had a band for the Queens celebration. There is a lot of singing, someone is coming in tomorrow. Three ladies who play the ukulele visit regularly. The people love it and join in". One of the deputy managers had formed a ukelele band who performed for people and had brought a vintage car to the home for people to see and talk about.

On the first floor there was a cinema room with a wide choice of DVD's, a sensory room with a fish tank and a hair salon. Opposite these rooms was a window overlooking the garden, with two armchairs and a table with books and magazines.

People's bedrooms contained their personal affects and were homely and individualised. Each person's name was outside of their room, along with a memory box of items for some people, which would help them to recognise their room and assist staff to engage with them.

The home had a coffee shop that had been open since April 2016. There was a notice on the door showing opening times. Tea and instant coffee were free of charge or a 'pod' coffee could be purchased. There were a

good variety of goods available for purchase, ranging from chocolate and crisps to nail files and gifts. The manager of the shop told us "We are not allowed to make a profit". Five people were sitting having coffee. The atmosphere was jovial and relaxed, with lots of interaction between people and the shop manager. People clearly enjoyed using the coffee shop. Their comments included: "We're very lucky aren't we"; and "It feels like we are out of the home".

Records were kept of activities that where offered and provided for mental stimulation, social and recreational purposes. Activities included a book club, poetry corner, bingo, internet café, quizzes, arts and crafts, sing-alongs and reminiscence. Church services also took place at the home. People's care records contained daily diary notes completed by staff that included evidence of staff interacting with people and responding to their needs and wishes. For example, one person had been on a planned outing and on another day had requested support to go out into the garden, where they had played a game of draughts with a member of staff and other people. Other people's records also showed staff engaged them in one to one activities and conversation.

The deputy managers told us about plans to improve the activities programme for people who were cared for in bed and who may require or benefit from more stimulation and one to one interaction. A list of people this applied to had been drawn up and discussions with staff were taking place, not only about activities but also how staff recorded the ways they already engaged with people on a daily basis. An example given was a member of staff had identified a shared interest in motorcycles and aeroplanes though talking with a person about the pictures in their room. The person had not been communicative before this.

There were trolleys on each unit containing a range of activities care staff could use to engage with people. One person had a box of particular activities, which had been given to them following a 'dementia mapping' assessment. We saw the person was engaged using the box of activities, which included sensory objects. (Dementia mapping is an observational tool that looks at the care of people living with dementia from the viewpoint of the person with dementia. The results can assist with the development of person-centred care). A member of staff told us staff had all been given information about the dementia mapping activity. They said it was useful in helping staff in "Making sure people aren't left out". Another member of staff spoke about the importance of "Seeing beyond the dementia, seeing the person".

Information about how to make a complaint was displayed on the notice boards in communal areas and people told us they would feel comfortable raising any concerns. There was a system and procedure in place to record and respond to any concerns or complaints about the service. The registered manager told us they had received no complaints about the service in the last 12 months. Staff understood people's needs well and demonstrated how they would be able to tell if a person was not happy about something, which meant that people would be supported to express any concerns.

Good

Is the service well-led?

Our findings

The registered manager worked in partnership with external health and social care agencies to promote people's health and wellbeing. This included following appropriate safeguarding procedures to help ensure people were protected when any concerns were raised.

A community care professional told us the service communicated well with them to help ensure the best outcomes for people using the reablement service. "This is where Forest Court exceeds….They have had some good outcomes where individuals were going to placement and have actually returned home with a package of care, as they have been able to have their confidence and independence back". They said this started from the management team assessing people in hospital for the reablement beds. "The AP (assistant practitioner) who is the lead for the reablement unit ensures the person who is coming in is supported in their new environment and paperwork is in place and is a valued member of the team, due to her knowledge and training on doing her role to high standard". They also told us they were aware of people in the other (non-reablement) units at Forest Court and said "There is no difference on the units with the care that is provided. The staff are working to a standard that the management expect to be provided".

The registered manager was promoting an open and inclusive culture within the service. They carried out walkabouts to check what was happening on the floor and had an open door policy for people living in the home, staff and relatives. A nurse told us "Management are fantastic, very diplomatic, open door policy and flexible" and "Staff here really support each other". Another nurse told us "Management are very good, they are very approachable". An assistant practitioner said the management team were "Very supportive; they are relaxed but very strong. You feel you can go to them".

Records of team meetings confirmed that staff were asked for their input in developing and improving the service. Staff had been consulted and involved in decision making when staff deployment within the units had been reviewed. The assistant practitioners took part in the nurses meetings, which promoted team working. An assistant practitioner said "I can't say how happy I am to be doing this role". They told us the management team had been very supportive of their application and wish to progress and develop their skills. Staff were clear about their own and others roles within the home. One member of staff said "Everyone knows who's doing what".

Staff were motivated to provide high quality care. One of the nutritionist care staff was doing a relevant academic qualification independently. Another member of staff said "It's a lovely home, I love working here".

The service used feedback to drive improvements and deliver consistent and high quality care. A satisfaction survey was carried out that included questionnaires sent to people who used the service and their relatives. The outcomes of a survey in March 2016 had resulted in the carpeted areas in the lounges being increased to reduce noise levels. Smaller portions of food had also been introduced following feedback. Residents and relatives meetings were held and actions recorded.

Regular audits of the quality and safety of the service took place and were recorded. For example, there were audits of care plans, medicines, infection prevention and control and equipment. In addition to these, a service manager for the organisation carried out regular checks that were also recorded. The registered manger maintained a record of actions taken in relation to audits, incidents, and feedback from people using the service or others acting on their behalf. A copy of the report was sent to the service manager and provider. A recent audit by the provider had focused on care and support plans, as a result of which senior care staff were given the role of checking that information matched up across various records, such as care summaries and medicines administration records.

Records showed that investigations were undertaken following incidents and that appropriate actions were taken in response. For example, in the event of a pattern of falls being identified, the provider's internal local governance team would contact the home to check what action was being taken to reduce the risks of similar accidents happening again. Falls were also discussed in staff team meetings to help reduce the likelihood of falls occurring.

The provider and registered manager had introduced a number of changes and innovations to improve the service. A new 'house keeper' role was being piloted at the home, which was designed to increase accountability and maintain clear standards of cleanliness within the service. Other changes included the nutritionist and assistant practitioner roles, second (10am) morning handovers, recruitment of additional staff to the activities team, and changing the management team rota to ensure improved cover during weekends. The daily 10am meetings had been inspired by an initial staff meeting to discuss and prepare for possible contingencies and responses during a doctors strike, which demonstrated the service was proactive.