Embrace (South West) Limited

Sherwood Forest Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The last inspection of the home was carried out on 14 May 2014 when we found people's records did not offer an accurate record of their care. We asked the provider to improve the way they recorded people's food and fluid intake and how people were supported at the end of their life to check the effectiveness of the care provided. We found during this inspection, improvements were still required.

Sherwood Forest Care Home provides nursing and residential care for up to 75 people many of whom are living with dementia. At the time of our inspection there were 65 people in residence. Accommodation is divided into two units, referred to as Sherwood View which provides general nursing care and Forest View which provides care to people living with dementia. Each unit has their own communal areas and bedroom facilities.

The service had two registered managers, one for each unit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had systems in place to identify how many staff was needed to support people with their care. The provider was unable to demonstrate how staff shortages were covered which meant there may not have been enough staff to meet people's needs.

People's consent to care and treatment was not fully sought in line with legislation and guidance. There were people at the home who were subject to the Deprivation of Liberty Safeguards (DoLS). Some staff had an understanding of the requirements of the Mental Capacity Act 2005 and DoLS. We spoke with staff about mental capacity and staff were unable to consistently describe what this meant in terms of people's care.

People's nutritional needs were not always met. People received additional health care support when required. However care was not always provided in line with people's care plans to minimise risks to people's health and wellbeing.

Records we looked at showed there were systems in place to assess and monitor the quality of the service. Care plans did not always state when people received care.

People were treated with dignity and respect. Staff supported people to maintain their independence by encouraging them to care for themselves whenever possible.
Staff received regular supervisions and appraisals, which meant that staff were properly supported to provide to people living at Sherwood Forest Care Home.

We saw medicines were managed safely at the home which meant that people received their medicines when they needed them.

People we spoke with told us they knew how to complain. We saw there was a complaints procedure in place which was displayed in the home which detailed how complaints would be handled appropriately.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff to meet people's needs.

People received their medications as prescribed and when they needed them.

There was a suitable recruitment process to ensure staff were safe to work with people.in a caring environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent to care and treatment was not fully sought in line with legislation and guidance.

People enjoyed their meals and were supported to eat and drink sufficient amounts to support their health and well-being.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received.

We saw people's privacy and dignity was respected by all staff.

Is the service responsive?

Good

The service was responsive.

The service supported people to undertake activities in and outside the home.

The provide had a complaints policy and process in place. People who used the service knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Documents in care plans did not always record when care had been delivered.

There were two registered managers in post.

People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning or improvement when required.

Sherwood Forest Care Home

Detailed findings

Background to this inspection

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

This inspection visit took place on 29 March 2016 and was unannounced. It was carried out by two inspectors, a specialist advisor with experience of nursing care for people living with dementia, and two experts-by-experience. An experts-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by experience on this inspection had personal experience of using or caring for someone who uses this type of service.

Sherwood Forest Care Home is registered to provide nursing care and accommodation for up to 75 people and specialises in the care of older people. Accommodation is divided into two units referred to as Sherwood View that provides care to people who require nursing and Forest View that provides care to people living with dementia. At the time of the inspection there were 65 people living in the home.

Prior to 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 improvements they plan to make. We reviewed the information we held about the service including previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service. We also received feedback from commissioners who fund care for some people.

We spoke with 23 people who lived at the home, eight visitors and 11 members of care staff. We also spoke with the regional manager who was available throughout our inspection in the absence of the two registered managers.

We spent time observing care practices and interactions in communal areas to understand people's experience of care. We observed lunch being served.

We looked at a selection of records which related to individual care and the running of the home. These included eight care plans, three staff personnel files, minutes of meetings and records relating to the quality monitoring within the home.

Requires Improvement

Is the service safe?

Our findings

We spoke with staff, visitors and people living at Sherwood Forest Care Home who shared their views as to whether there was sufficient staff to meet people's needs and keep them safe. Their views were mixed. One person who lived at the home told us, "I am happy and safe in the home." A visiting relative commented that they could do with, "More staff". Another relative told us, "I'm not sure more staff would be any good because there are always people about."

Four members of staff we spoke with felt that there was not enough staff. One member of staff told us, "It's a bit poor. It could be better," and that "It is hard work at lunch time to ensure they [people] get their food before it goes cold. When we are short staffed it is not good." Another staff member said, "It took until 12:00 (midday) to finish breakfast meds." One member of staff told us they thought they managed okay at meal times and that the nurses help at meal times.

The regional manager told us that staffing levels depended on the amount of staff needed for care and that this was regularly assessed using a 'dependency tool' to measure the staffing hours needed. We saw the dependency tool for the past three months and this demonstrated that that the number of staff increased or decreased depending on people's needs and how many people were living at Sherwood Forest Care Home

We saw the staff rota for the Forest View unit that covered 28 March 2016 to 3 April 2016. This showed there was one qualified nurse and that there should be five carers for the morning and four in the afternoon. On four out of seven days there were less than five carers in the morning and on one out of seven days there were less than four carers in the afternoon. The rota did not indicate how staff shortages had been covered. This meant that there may not have always been enough staff available to support people needs.

People told us they felt safe living at Sherwood Forest Care Home. A person living at the home told us, "I come here for respite care and stay for two or three weeks. Time after time, after time, I come here as I feel safe." One visitor told us that their relative was safe living at the home and that they had, "No problems with care and is safe here."

We looked at how the provider protected people and kept them safe. We saw that the provider had systems and policies in place that ensured safeguarding (protecting people from abuse) concerns were reported to the local authority and us. These were also on display within the corridors; this helped to promote people's awareness of abuse and informed people how to alert agencies of their concerns. The provider also had a whistleblowing policy that enabled staff to report concerns anonymously.

Staff spoken with said they had received training about safeguarding procedures as part of their induction training and knew where to find the procedures if required. They understood the type of abuse that could occur and their responsibility to report concerns. Staff told us that they felt comfortable raising safeguarding concerns. Staff training records that we looked at confirmed that they had received the training.

Each person living at Sherwood Forest Care Home had a care plan that detailed the needs and support that

people required. The care plans detailed the role of staff in meeting people's needs safely with regards to the use of equipment. We saw that where equipment was required the appropriate support was given to move people safely. Corridors were free from obstructions and well-lit to enable people to find their way to their bedroom, toilet or the lounge in a safe manner.

We saw that safety checks of the premises and equipment had been completed and records were up to date. This ensured that risks presented by the environment were managed and reduced to ensure people's safety.

There was a fire evacuation procedure on display within each unit. Each person had been assessed to identify risk in the event of an emergency and people had personalised evacuation plans in place.

Staff had emergency documents for each person should they need to be admitted to hospital. These documents would be readily available and would remain with the person during an emergency situation. This was important as some people were unable to communicate verbally.

We saw that call bells were available should people need to summon assistance however a staff member told us that most people were not able to use a call bell. They told us that to ensure people were okay, staff checked on people in their rooms every hour. A different staff member told us, "If a person is nursed in bed we have charts. We go in regularly and record what we have done." We saw records that showed that people were checked frequently. This meant that staff were able to monitor people to ensure they were safe.

Staff we spoke with confirmed that they completed an application form and a police check before starting work. The provider had a recruitment system in place. We looked at three staff recruitment files. All of the files showed checks which had been completed before staff began work. These included disclosure and barring service (DBS) checks, a DBS check is completed before staff began work as helps employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to commence employment.

People told us that they received their medicine as prescribed and at the time of day it was meant to be administered. One person told us, "My medicines are given on time and the nurse makes sure I take them." Another person told us, I get my medicine and know which one is which."

We looked at the medication administration records (MARs) for 43 people. The MARs recorded when medicines were delivered by the pharmacy, when they were administered or if they were refused. This gave a clear audit trail and enabled the staff to know what medicines were available for people. We checked these records against the stock held and found them to be correct. This meant that medicines were managed, stored and administered correctly.

The MARs also contained a photograph of the person who the medicine was prescribed for; this ensured staff administered the correct medicine to the correct person. Records showed that people were getting their medicines when they needed them. If a person refused to take their medicine, this was clearly recorded and the reason documented so that staff could take action as necessary to address the situation.

We looked at MARs for people who had been prescribed pain relief as required. These detailed what signs or symptoms a person might display when they were in pain. It also documented common side effects a person might display upon being administered the medicine. This enabled staff to identify when a person

might need their 'as required' medicine so staff could administer it safely. We found that people were supported to receive their medicine as directed by the doctor.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

People can only be deprived of their liberty to 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 and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

Staff told us that some people were not able to make certain decisions. One staff member said, "We have a lot of people who have not got capacity. We try to maintain things for them and try not to take things out of their hands." Within the Sherwood View unit we saw people had general capacity assessments completed, but these did not relate to a specific decision. There was also no evidence as to how any decisions made on behalf of people who lacked capacity were being made in their best interests.

Even though some staff had told us that they had received training to increase their knowledge and understanding of the MCA, we found that some staff were not able to consistently reflect this in their work and appreciate what their responsibilities were. The provider had not considered completing their own assessments regarding decisions that they would be making on a day to day basis for people who lacked capacity.

There were people who used the service that staff believed lacked capacity to make certain decisions and were also being restricted of their liberty. At the time of our inspection, DoLS applications had not been made to authorise these possible restrictions of people living within the Sherwood View unit. For example, we saw that three people had bed rails in place which prevented them from getting out of bed. Their care plans did not document that the relevant application for the use of bed rails from the Supervisory Body was made. This demonstrated that the provider had not always considered if people were being restricted unlawfully.

This was a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However staff working within the Forest View had good understanding of the MCA and DoLS. We saw in care plans of two people in the Forest View unit that capacity assessments had been completed for the use of bed rails to prevent the person from falling and for consent to providing care and administering medicines. We saw that best interest decisions had been made with the person's family and family members had signed to show that they agreed with the decision rather than providing consent on the person's behalf. The relevant applications in relation to the use of bedrails were submitted to and approved by the Supervisory

Body. This meant people were not being restricted without the required authorisation.

People's nutritional needs were assessed regularly and there was information in care plans detailing what these were. Changes to people's diets were documented and communicated to the kitchen staff. However people's nutritional needs were not always met.

Some people did not receive the foods which were planned for them or met their preferences. We saw one person required thickened fluids and a pureed diet as they had been assessed to be at risk of choking. The staff we spoke with told us they varied the amount of thickener they used depending on the drink however the information in the person's care stated that every drink should be thickened to the same consistency. This meant staff were not following the correct instructions and the person was at risk of choking on inadequately thickened drinks. We saw that the same person was given pureed beef, potato and vegetables at lunchtime. We read in the person's care plan that they did not eat beef which meant they may not have been supported to maintain their dietary preference.

We observed that other people were supported to eat and drink. We spoke with people about the quality of food and they told us they had enough to eat and drink. We saw that snacks were available between meals and one person told us, "The atmosphere is good, [and] food is alright." Another person told us that, "The food is good."

One person said, "I have choice on food, alternatives are given when you do not want the food with choices." We saw two people that were asked by staff what they would like for breakfast. One person said, "A jam sandwich," the other person asked for "An English breakfast." We saw that people's choice was respected.

A visiting relative told us, "The home does inform us if he is unwell." We saw that dietary assessments had been completed and people were weighed regularly. We saw that one person had been referred to the doctor and dietician due to weight loss and dietary supplements had been prescribed. Malnutrition Universal Screening Tool (MUST) assessments were in place and had been reviewed monthly. So what?

People were supported by staff who had undertaken a thorough induction programme which gave them the skills to care and support people safely. Staff we spoke confirmed that they had already obtained a nationally recognised work based qualification or were working towards one.

Staff told us that several of them had worked for the provider for a number of years. This meant that people experienced a consistent approach to the care they received. For example, staff could explain how they supported individuals and how people preferred to be cared for.

People were supported by staff to maintain their health and wellbeing. People told us they were supported to attend routine appointments and records we looked at confirmed what people told us. One person said, "I only have to ask and I can see the doctor." Another person told us that, "Healthcare professionals are called if and when needed." We saw that staff followed the advice they received from health care professionals. For example, we saw that one person had been assessed by an occupational therapist for a specialised chair. Staff had recorded the advice and ordered the chair for the person.

Good

Is the service caring?

Our findings

People who lived at Sherwood Forest Care Home spoke well about staff and their attitude towards them. People told us staff were, 'helpful' and were kind to them. For example, one person told us, "I am well looked after." Another person commented, "The staff are decent, they help you and know what is needed."

There were a number of people whose first language was not English. The provider had recruited staff that were multi-lingual, this ensured that people using the service were able to express their needs and engage in discussions with staff. However, we observed that one person whose first language was not English was unable to express their views without the support of their relative. We discussed this with the regional manager who has confirmed he would be arranging additional training for staff and would also use signs and symbols in pictorial format to ensure the person was able to communicate more effectively with staff.

Throughout our inspection we saw that people were able to make choices about how and where they spent their time. We observed staff knock on people's bedroom doors before entering. We also saw when staff were attending to people they closed the door. That meant staff recognised and maintained people's privacy and dignity.

Staff we spoke with told us they encouraged as many people to maintain their independence as long as they were safe to do so. Throughout our visit, we saw that staff encouraged and prompted people to move around independently. This meant people's independence was promoted.

People were encouraged to develop and maintain relationships with the important people in their lives. People who lived at the home told us there was never a problem with the time people could visit them. Staff told us, "Relatives can visit whenever they want to." We observed when visitors arrived that they were able to sit with the person in the communal area or if the person chose to, they were supported back to their room for privacy.

Good

Is the service responsive?

Our findings

We saw meetings were held for people to get involved in identifying what activities they would like to do. People's relatives were involved in their care and support. One relative told us, "We were involved in the care planning and its review." We found evidence that the person and/or their relatives had been involved with developing their care plans. In addition people had signed care plans to indicate they agreed with the care and support provided to them. Four people we spoke with told us they were encouraged to express their views about how their care and support was delivered. Daily records completed were up to date and maintained. These described the daily support people received and the activities they had undertaken.

Care plans contained 'My Day / My Life' which was detailed and that the information was tailored specifically to each person's needs and their preferences for being cared for.

The provider told us in the Provider Information Return (PIR) that people received a full-pre admission assessment before people move in to Sherwood Forest Care Home. The pre-admission assessment identified a person's needs so that the provider could ensure they would be able to support them appropriately. The provider also told us that all individuals received a six monthly review and that staff would involve the person and their family and that they also hold resident and relative meetings.

We looked at care records of three people who lived at the home. Assessments of people's needs were completed by the provider as well as the placing authority before people moved into the service. The assessments were used to develop individualised care plans which contained risk assessments to reduce and manage known risks.

Staff confirmed that they complete a 'handover' when staff change shifts to ensure people's needs for the day had been communicated. We saw staff communication logs and handover sheets were completed. This meant that there was continuity of care between staff change overs.

One visiting relative told us, "There is no reason to question staff competency, they always treat people as individuals." Records we saw confirmed that staff were given the training they needed to provide them with safe working practices and to give them a knowledge and understanding of the needs of people they supported. Staff files that we looked at also confirmed that supervisions were regularly undertaken and that their competencies had been assessed."

People knew what to do if they had any concerns. The people and relatives we spoke with told us they would speak to the registered manager if they had a problem or concern and it was clear from discussions that people had a good relationship with the management team. One relative told us, "I've no complaints but if I did I'd feel comfortable speaking with the manager."

The provider had their complaint procedure on display in the main entrance. This explained how a complaint would be assessed, recorded and responded to. The policy also advised how complaints could be escalated should the person remain dissatisfied with a response.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in May 2014 we found that care records did not always contain sufficient detail including the recording of the total amounts taken for food or fluids or end of life arrangements to check the effectiveness of the care provided. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that documentation in relation food and fluid were in place however end of life arrangements required further improvement. For example people's resuscitation wishes known as 'Do Not attempt Cardiopulmonary Resuscitation' (DNACPR) was incomplete. One DNACPR had been completed when the person were in hospital. The person's DNACPR wishes had not been reviewed when they moved to Sherwood Forest Care Home and may not have reflected their current preference.

People's risk of harm associated with their care had been assessed however some care plans did not contain sufficient information about how the risks should be managed. We looked at care plans of three people and found that risk assessments identified that they were at high risk of developing sore skin. There was no clear guidance for staff on how often the people should have their position changed. A visiting relative told us, "We were told that [the person] has to be turned and two hourly checked. There are no charts that we can see as they are not kept in the room." We spoke with two members of staff who told us they supported people to change position every two to three hours but not always.

We checked the records for three people and saw that only one record provided evidence that they had been supported to change position as required. This demonstrated that the records did not provide clear guidance for staff on supporting people with fragile skin.

We also looked at a care plan of a person who had diabetes. The risk assessment identified that the person required checks to ensure their blood sugar levels remained stable. However there was no guidance for staff on how to recognise if people's blood sugar was too high or low or the action they should take. This meant that people were at risk of receiving poor care because staff did not clearly document how people's care had been delivered.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were regular resident and relatives meetings and this was confirmed by a member of staff and that they send letters to relatives to invite them. A visiting relative we spoke with told us, "There are relatives meetings, we get a letter about it," the relative told us they chose not to attend. The provider also commissioned an external provider to complete a resident survey to gain an independent view.

There were two registered managers in post who took responsibility for the day to day running of the two units. People who used the service and their relatives were complimentary about the registered manager(s)

and said they were visible and approachable. One member of staff told us, "The manager is very approachable. I can go to them at any time. They come out to us all of the time and they talk to the residents." Another member of staff told us if they had any concerns they could speak to the manager and they would get sorted. This demonstrated that staff felt comfortable and able to raise concerns with management

We looked at the systems used for monitoring the quality of the service. We saw the provider looked at a variety of audits. We saw the systems were effective in identifying where improvements were needed and action plans had been produced which were monitored by the provider to ensure the improvements were being made. For example the audit identified that there was an issue with the bin stores on the premises and the manager had taken action to address it.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent This was because the service did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance As people's care records were incomplete and their end of life wishes not clearly documented or reviewed.