The Wilverley Association

Forest Oaks

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14, 15 and 21 August 2017 and was unannounced.

Forest Oaks is a purpose built residential and nursing home for up to 46 people which is located in the centre of Brockenhurst and is run by the Wilverley Association. The Wilverley Association (the provider) is a charitable organisation run by a board of Trustees who meet on a regular basis to discuss and decide on all issues concerning Forest Oaks and their other nearby service. At the time of our inspection there were 38 people living at the home.

The home is arranged over three floors which are accessed by both stairs and a lift. The Loriston-Clarke Wing on the ground floor provides care for up to 16 people who have more complex nursing needs. The Hindson Wing provides general residential and nursing care for up to 29 people.

The home has a number of communal sitting areas, a dining room, a hair salon and a garden with outdoor seating areas. The home has both external and internal CCTV for security and to provide reassurances people living at the home that the environment is safe. The internal CCTV is in the communal areas only and people living at the home have been consulted about and given consent to its use.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Since our last inspection, 2 new managers had been appointed, but both had left after a short time in the post. In the interim, the service had been supported by senior staff appointed by the provider. This had been an unsettling time for staff and morale had been low. A new manager had recently been appointed and at the time of the inspection had been in post for six weeks.

Following our last inspection, improvements had been made to ensure there were sufficient numbers of staff deployed in the home at all times to meet people's needs safely. Some people felt more could still be done to increase the staffing levels to improve further the responsiveness of staff. Moving forward, the provider planned further improvements aimed at introducing a more flexible workforce with more staff being rostered at times when observations or call bell analysis showed people's need for support was greatest. The manager told us it was planned to have this in place by October 2017.

Improvements had also been made to ensure that notifications about important events which happened within the service were submitted to Care Quality Commission (CQC).

However, we found some areas for improvement. Whilst staff were caring and compassionate, people did not always receive appropriate end of life care.

Staff had not been receiving regular supervision or completing the Care Certificate in a timely manner. The training programme needed to be more robust.

The provider had not ensured there were effective systems in place to ensure compliance with the Regulations and to assess, monitor and improve the quality of care provided.

People's records still did not consistently contain sufficient information about their needs and how these should be met or about people's preferred daily routines. This had also been a concern at our last inspection.

Recruitment checks needed to be more robust. The provider was not able to demonstrate that appropriate risk assessments had been undertaken regarding the decision to recruit a member of staff currently under investigation by their professional regulator.

Improvements were needed to ensure that all of the risks to people were appropriately managed.

Medicines requiring refrigeration were not being stored appropriately. People were not always receiving their medicines as prescribed. Staff were not consistently recording when topical creams had been applied.

Staff understood how to recognise and respond to abuse. People were encouraged to express their choices and these were respected. People's human rights were protected as the leadership team understood the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People told us the quality of food provided was improving. People received a choice of meals and were supported appropriately to eat and drink.

People told us they were cared for by kind and caring staff who respected their choices, their privacy and dignity and encouraged them to retain their independence.

People told us they were able to raise any issues or concerns and felt these would be dealt with promptly.

People and staff told us they had a growing confidence in the new leadership of the service.

Plans were in place to suspend new admissions to the home to allow for a period of time during which the management team could oversee the delivery of improvements and a leadership and competency based training programme.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment checks needed to be more robust. The provider was not able to demonstrate that appropriate risk assessments had been undertaken regarding the decision to recruit a member of staff currently under investigation by their professional regulator.

Improvements were needed to ensure that all of the risks to people were appropriately managed.

Medicines requiring refrigeration were not being stored appropriately. People were not always receiving their medicines as prescribed. Staff were not consistently recording when topical creams had been applied.

Improvements had been made to ensure there were sufficient numbers of staff deployed in the home at all times to meet people's needs safely.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect and about what they must do if they suspected abuse was taking place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been receiving regular supervision or completing the Care Certificate in a timely manner. The training programme needed to be more robust.

People's human rights were protected as the leadership team understood the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People told us the quality of food provided was improving. People received a choice of meals and were supported appropriately to eat and drink.

People received and were supported to access healthcare

services when needed.

Is the service caring?

Good

The service was caring.

People told us they were cared for by kind and caring staff and were treated with dignity and respect.

People were empowered and encouraged make decisions about how their care should be provided and staff did not restrict people's choices and interests.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The lack of knowledge by some nurses meant we could not be assured everyone had received appropriate end of life care.

People's records did not consistently contain sufficient information about their needs and how these should be met.

People took part in activities of their choice which they enjoyed and helped to reduce the risk of social isolation.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home did not have a registered manager in post. A new manager had been appointed in early July 2017 although they had not as yet applied to register with the CQC.

The provider had not ensured that there were effective systems in place to ensure compliance with the Regulations and to assess, monitor and improve the quality of care provided.

People and staff told us they had a growing confidence in the new leadership of the service.

Plans were in place to suspend new admissions to the home to allow for a period of time during which the management team could oversee the delivery of improvements and a leadership and competency based training programme.

Forest Oaks

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 was an unannounced inspection which took place over three days on 14, 15 and 21 August 2017. On the first day of our visit, the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. On the second day there were two inspectors and on the third day one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the service tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 14 people who lived at the home and 4 relatives. We also spent time observing aspects of the care and support being delivered. We spoke with the organisation's Chief Executive Officer (CEO), manager, head of professional practice, a clinical lead, a registered nurse, six care staff, the chef and a member of the activities staff. We reviewed the care records of four people in detail and checked specific elements of the care records for a further seven people. We also viewed other records relating to the management of the home such as audits, incidents, policies, meeting minutes, training and supervision records and staff rotas.

Following the inspection we sought feedback from three health and social care professionals and asked their views about the care provided at Forest Oaks.

The last inspection of this home was in June 2016 during which we identified two beaches of the Regulations. This was because the provider had not ensured there were sufficient numbers of staff deployed

in the home at all times to meet people's needs in a responsive manner. Notifications about important events which happened within the home had not been submitted to Care Quality Commission (CQC).

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Forest Oaks. One person told us, "I feel safe, comfortable and very happy here….I felt at ease from the moment I first came here". Another person told us, "I am very happy here, they really take good care of us, yes I feel safe and I always get my medication on time, including painkillers if need be".

Our last inspection found that the provider had not ensured there were sufficient staff deployed in the home at all times to meet people's needs. This inspection found that improvements had been made. Staffing levels had been reviewed and the numbers of staff deployed had increased. There were now two registered nurses on duty throughout the day (8am – 8pm) and during early shifts there were now eight care workers on duty with this reducing to six after 2pm. Night shifts were now staffed by one registered nurse and four rather than three care workers. We reviewed the rotas for a four week period; these confirmed the home was usually staffed to these target levels. The provider also employed a team of housekeeping staff, an administrator, chefs and kitchen staff, two activities co-ordinators and a maintenance person. We did note that there remained a high use of agency staff to cover gaps in the rota or sickness of staff. The CEO advised that recruitment remained a challenge. In the interim wherever possible the same agency staff were being used to provide as much consistency as possible.

Overall people's feedback about the staffing levels was positive. Comments included, "When you ring the bell, they come quickly most of the time" and, "They [staff] always come quickly, they are very good". One person did feel that on occasion it could be some time before staff attended, but they told us, "It has not been urgent and other people are here who need more help than me". We received mixed feedback about the staffing levels from relatives. Most felt they were adequate with one relative saying, "I have never once found there have not been enough staff". However another relative felt there were at times staff shortages.

Our observations indicated that people's needs were being met and that staff, whilst busy, also had time to chat with people. During the inspection, we accidentally stepped on a person's sensor mat; staff were very quick to respond. Staff were generally positive about the numbers of staff deployed and indicated that these enabled people's needs to be met. However, most felt the use of agency staff needed to be reduced and that one more care worker on shift would enable them to be even more responsive to people's needs. The manager told us further improvements to the workforce were planned. The objective was to deploy staff in a more flexible manner, with greater numbers of staff on duty when people's need for support was highest, such as at meal times. To do this, the leadership team were first working evening, weekends and nights undertaking observations and analysing call bell data to really relate staffing to care delivery. It was envisaged that plans to suspend new admissions to the home would allow the leadership team to reduce the use of agency staff and allow time to embed this new system.

Improvements were needed to ensure that all of the risks to people were appropriately managed. Where people were losing weight, this information was still not being effectively shared with kitchen staff so that the provision of fortified and high calorie diets could be offered. In the case of five people, tools used to assess the person's risk of developing skin damage had not been completed correctly or consistently. This

limited their effectiveness as a monitoring and risk management tool. One person's medicines care plan said 'check BM's [blood glucose readings] at least weekly'. This was not happening. Records showed the person's blood glucose levels had been monitored on the 14 July 2017 and then again on 1 August 2017, but not since.

Some of the tools being used to monitor and review risks to people's health and wellbeing were not being consistently used. For example, where there were concerns about a person's food or fluid intake we were able to see charts were used to monitor this. However, the fluids charts were not being fully completed which limited their effectiveness as a monitoring tool. For example, staff were not recording the person's target fluid intake and had not always totalled how much fluid people had taken at the end of each day. A target fluid intake is specific to each person and is important because it helps staff to check that the person is having sufficient fluids to remain hydrated. This had been a concern at our last inspection.

Some risks were more effectively managed. People had moving and handling risk assessments and falls risk assessments. Alarm mats were used to alert staff when people at high risk of falls were moving so that they could check on their safety. Staff were able to tell us about which people they needed to respond to immediately due to their high risk of falling. Where people were at risk of falling from bed, crash mats and bed rails were used once appropriate consent and risk assessments had been completed. In light of a previous incident in the home, when a suction machine was found to not be working, we checked the three suction machines used by the service. All were found to be in working order and regularly checked. Suction machines are used to remove substances or blockages from people's airways to prevent them choking. People had a care plan that considered whether they were able to use their call bell to summon assistance. Where people were able to use their call bell, we observed they had this in reach.

People were protected from risks associated with the environment. Each person had a personal emergency evacuation plan which detailed the assistance they would require for safe evacuation of the home. A fire risk assessment had been completed in March 2017 and fire equipment tests were up to date and staff were trained in fire safety. The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. A general risk assessment of the service had been undertaken by an external contractor in March 2017 and had reviewed risks in relation to a range of areas including electrical safety, legionella and the operation of the lift. Where actions had been required these had been completed. Issues relating to the environment were reported and addressed quickly by the maintenance person.

Recruitment checks needed to be more robust. The provider was not able to demonstrate that appropriate risk assessments had been undertaken regarding the decision to recruit a member of staff currently under investigation by their professional regulator. Full employment histories had not always been obtained in line with the Regulations. The provider had obtained references from previous employers and checks had been made with the Disclosure and Barring Service (DBS). These checks help to ensure new staff members had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals.

We found that some areas of how medicines were managed required improvement. Some people's medicines, including insulin, needed to be stored in a refrigerator. Whilst the temperature of the medicines fridge was being monitored the records showed the temperature had been recorded as being outside of recommended ranges for several months. The manager told us a new medicines fridge had been on order for months and during the inspection a new medicines fridge was installed. However, we could not be

assured that the provider had taken sufficient action to address this. Storing medicines at the correct temperature is important to ensure they remain effective.

Each person had a medicine administration record (MAR). These contained all of the required information to support the safe administration of people's medicines such as a recent photograph and information about any allergies they might have. However, we found some areas where improvements were needed. Some people's MARs contained handwritten entries which had not been checked for accuracy and signed by a second staff member. This is not in line with best practice guidance. We noted that one person had not received one of their evening medicines on 14 occasions in August. Staff had recorded on the MAR that the person was sleeping. Staff had not contacted the GP to discuss whether it might be appropriate to review the times the medicine could be given. Action has now been taken to address this. Where people were prescribed topical creams, topical cream administration records (TMARs) were in place, but staff were not consistently recording when creams had been applied.

Improvements had been made to ensure that in most cases, personalised PRN protocols were in place. These protocols help to ensure that all staff, including agency workers, are able to provide a consistent response to people's individual signs of pain particularly where people were no longer able to communicate this. Controlled drugs were stored securely. We completed a random audit of the controlled drugs in stock and found records were accurate. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect and about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the manager and were confident they would act on these.

Requires Improvement

Is the service effective?

Our findings

People's feedback about the care provided was mostly positive. One person told us, "There is plenty to do, the staff are all very considerate and polite, the food is excellent, I couldn't be in a better place". Another person said, "The care is very good". Each of the people we spoke with said they would recommend the home to others. A relative told us their fathers care had been, "Brilliant".

However, whilst people told us they felt they received effective care, we found some areas where the effectiveness of the service provided required improvement. Improvements were needed to ensure that all staff received appropriate induction, supervision and training to perform their role effectively. The manager told us all new staff would have a minimum of three shifts shadowing more experienced workers and would also undertake some essential training such as moving and handling and fire training. However, it was not clear that sufficient time had been set aside for new staff to learn about people's needs and to read their care plans. For example, one care worker had been employed at the service for four months but told us they had still not had a chance to read each person's care plan. It was the provider's policy that staff, new to care, complete the Care Certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate and should ideally be completed within the first 12 weeks of employment. Records showed that staff were not completing this in a timely manner and therefore the provider could not be confident of their competence, skills and knowledge.

Staff completed online training in subjects such as infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding, equality and diversity and manual handling training. Most of the training was required to be refreshed very three years with the exception of the moving and handling and safeguarding training which was refreshed on an annual basis. A review of training data showed that most but not all of the training was up to date. For example, 50% of staff did not have current safeguarding or basic life support training. Our last inspection had identified that care workers did not undertake training in caring for people who lived with dementia. Records showed that only one staff member had undertaken this training since our last inspection despite the provider's records indicating that one third of the people using the service were living with dementia. Staff did not have food hygiene training. Food hygiene is included in the Skills for Care recommended minimum learning and development required by staff working in adult social care settings. The CEO told us that they had recognised that staff would benefit from this training and that this was being introduced as an e learning package for staff.

The findings from this inspection and those of the head of professional practice employed by the provider indicated there remained a number of areas where both care and nursing staff needed to develop their skills and knowledge. For example, further training was needed in end of life care and in understanding how to care for people with dysphagia. However, progress with rolling out training in these areas had been slow. For example, only five staff had completed end of life care training. We had, at our last inspection, been told there were plans to implement the Gold Standards Framework (GSF). The GSF provides a framework for best practice in relation to end of life care. This framework had not been fully implemented. Training planned with the local hospice on the management and support of people with end of life care needs had not taken

place. An end of life health care specialist told us the service could make more use of their free training sessions and link more effectively with their service through attending their link nurse sessions which Forest Oaks did not currently do. The head of professional practice told us there were now plans in place for Forest Oaks to introduce the Six Steps Programme. This programme leads to a recognised qualification in end of life care. A training session was being undertaken during our inspection which covered areas such as dysphagia, prevention of falls and skin care.

In addition to these concerns about the robustness of the training programme, we found the provider had not ensured all staff had been provided with regular supervision. Supervision is an important tool and helps providers and managers be confident that staff understand their role and responsibilities. The provider's policy stated staff should receive supervision four times each year. None of the care workers we spoke with had received formal supervision in the last 12 months; this was despite the home and staff group going through a period of change and uncertainty. One care worker told us they missed not having regular supervision. They said, "It gives you feedback and a chance to talk about what you would like to do".

The failure of the provider to ensure staff had been adequately supported to perform their role and responsibilities effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

Since the new manager and head of professional practice had been appointed, staff told us they were feeling more positive and well supported and some supervision and coaching sessions had begun to take place. Annual appraisals were due to take place shortly. One staff member said, "I now feel well supported, if I have a problem I can go to [head of professional practice]". Since the arrival of the new leadership team, an individual supervision programme was starting to be rolled out and we were advised that group supervisions were also taking place. We saw a sample of these for a registered nurse and a care worker. There was evidence that the new leadership team were committed to a continuous learning cycle and there were plans to implement both a more robust induction and training programme from October 2017. We were advised that the new training programme was evidence based and included a three-day leadership workshop and a six-month programme for staff consisting of one day a month focusing on areas such as robust record keeping, person centred care, nutrition and hydration, skin care, mobility and managing falls and safeguarding. To support the delivery of this training programme new admissions to the home had been suspended to enable staff to have the time to learn and engage with the programme.

It was evident that some improvements had been made to the environment. Some of the communal areas and the activities/ hobby room had been redecorated and new furniture purchased. However more needed to be done. For example, some of the carpets in communal areas were worn or had areas where the carpet was stuck down with tape. Records showed the provider had an ongoing refurbishment plan in place to provide improvements to the environment, however, some of the improvements were now more urgent in order to ensure the environment continued to be a pleasant place to live and enhanced people's quality of life.

People living at Forest Oaks were mostly able to make their own decisions and give to consent to their care and treatment. Care plans contained signed consent forms which recorded the person's agreement to have their photographs taken, to have flu jabs or for information about them to be shared with health and social care professionals. Where consent forms had been signed by relatives, we were able to see there was evidence that the relative had legal authority to do so.

People were encouraged by staff to remain in control of their care and support where able. For example, a number of people self-administered their own medicines following the completion of risk assessments. Staff

respected people's choices and did not restrict their interests; instead they were encouraged to take walks into town and to retain their independence in the knowledge that staff were on hand to assist if needed.

People's rights were protected as the leadership team understood the requirements of the Mental Capacity Act (MCA) 2005. The MCA 2005 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. Where a person's ability to consent to their placement or aspects of their care plan was in doubt, a formal assessment of their capacity had been undertaken as part of the care planning process. Where necessary staff had been involved alongside other professionals and family members in reaching best interests decisions about how people's care and support should be provided. We have asked that senior staff review the risk assessments and support for one person with fluctuating capacity to understand the risks of leaving the building without support to ensure this contains sufficient guidance for staff on how to manage and assess this risk on a daily basis.

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 the Deprivation of Liberty Safeguards (DoLS). Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

Overall, people were supported to have enough to eat and drink and they told us they usually enjoyed the food provided. One person said, "The food is always very good and you always get a good choice on the menu". Another person said, "The food is alright, not fine dining, you know, but there is a good selection". Prior to lunch people gathered in the lounge for sherry. We observed that people seemed to enjoy this opportunity to meet and chat about the activities they had taken part in but also about upcoming events. Lunch was served in the dining room, or taken in a hot trolley to each floor before being delivered to people in their room on trays. Some people needed assistance to eat and drink. We observed that overall, this was managed in a person centred and safe manner. We observed the lunch time meal on the first day of our inspection which, although quiet, appeared to be a pleasurable experience for people. Fresh fruit, tinned soups and baked beans were readily available in the kitchenettes throughout the home which were used by some people to prepare their own breakfast or light snacks. Hot and cold drinks were also readily available and served with cake or biscuits mid-morning and afternoon.

The provider used an outside caterer to provide the food within the service and we met their chef manager. They explained they were provided with information about people's specialist diets including those that required diabetic meals and those that needed soft or pureed food. The information provided to the chef was displayed within the kitchen. Where people required a pureed meal, each element of the meal was pureed separately to ensure people were still able to taste the individual flavours.

Where necessary a range of healthcare professionals including GP's, dentists and speech and language therapists, had been involved in planning people's support. Each week, a GP made a routine visit to the home during which they were able to review people about whom staff had concerns or who were presenting as being unwell. A healthcare professional told us staff referred people to them in a timely manner and appropriately. People's care records contained information about their medical history and records were maintained of the outcome of medical appointments and visits from the GP or other healthcare professionals. One person told us they had visits from their doctor regularly including at short notice if needed. They explained that they had recently had a problem with their leg and that all of the staff were very good regarding their treatment.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person told us the staff treated her with respect and were polite. They said, "Some of the staff are absolute darlings and the new girl seems very nice". Another person said, "The staff are always very polite and caring". A third person said, "Nothing needs improving really, 90% of the staff are very attentive and caring, you always get one or two". A relative told us that when the manager and head of professional practice had visited their father in hospital, their approach had, "Oozed compassion". A health care professional told us, "I think the residents are very well cared for by the nursing staff who clearly show dignity and respect for their residents and attend to them in a timely and compassionate way".
Staff spoke fondly about the people they supported and assisted them in a kind and caring manner. A staff member told us, "We spend one to one time with people, chatting about the old times, [person's name] is an Arsenal fan and I'm Chelsea". The care worker explained that they often had some banter with the person about football.

People looked relaxed and happy in the company of the staff who, throughout our visit appeared, attentive and happy in their work. One person told us, how they felt very much at home at Forest Oaks, they said it was, "Just like being on holiday". Another person said, "It's like a big family here". A third person told us how proud they were of Forest Oaks and of how respectful, caring and polite the staff were, especially the management.

We observed a staff member supporting a person. The staff member was kind and patient and supported the person in a sensitive manner, providing clear instructions and gentle encouragement. The care worker told the person, "You are doing really well; no you are not letting anyone down".

Many people living at Forest Oaks were able to understand and make decisions about how their care and support was provided and they were empowered and encouraged to do this on a daily basis. For example, some people chose to manage their own medication. A care worker told us how they encouraged people to choose what clothes to wear and which meal they would like to eat. Staff confirmed people could also express a wish about whether to have a male or female care worker and that their choices would be respected. The kitchenettes were fitted with washing machines and tumble driers with some people using these to manage some of their own laundry. Following appropriate risk assessments, some of the kitchenettes also had hot plates and kettles and fridges which allowed people to prepare their own meals or snacks. People with more complex needs were also encouraged to be as independent as possible. Staff told us how they encouraged people to complete small tasks such as washing their own face.

People told us they were treated with dignity and respect and in the 'Residents survey' undertaken in January 2017, 100% of people agreed they were treated with dignity, kindness and compassion. The majority of our observations confirmed this, although we did at one point hear staff refer to people as 'feeds' rather than by their name. This is not person centred care. Staff told us how they knocked on people's doors before entering, or placed a towel across the person's lap when assisting them with personal care.

People were supported to follow their religious and spiritual beliefs. Songs of Praise gatherings were held and the local vicar visited the service to offer pastoral support. Some people had end of life or advanced care plans which had been drafted with the person and their relatives and described the person's wishes in relation to how they would like their care and environment to be managed in their final days. We could not be confident that one person had been given sufficient opportunity to be involved in the decision to have a 'do not resuscitate' order made. When do-not-attempt-cardiopulmonary resuscitation (DNACPR) decisions are made by clinicians because emergency first aid would not be successful, best practice guidance states that it is expected that the person would still have the decision and the reasons for it explained to them. We have asked the manager to discuss this person's DNACPR decision with their GP to ensure that the decision has been reached in line with this guidance.

The provider, the Wilverley Association, had developed a new set of values that reflected the organisations aims and objectives. These included being faithful, honest, compassionate, valuing family links and being welcoming. Our feedback from people living at Forest Oaks and increasingly from the staff team was that the manager led the service in a manner that was in keeping with these values. People felt safe and respected and were encouraged to maintain their links within the local community.

Requires Improvement

Is the service responsive?

Our findings

People living at Forest Oaks voiced no concerns to us about the care they received and our observations and inspection findings found that most people received care that met their needs and that the staff team were committed to providing the best care possible. However, we also found that a small number of people with more complex needs did not consistently receive care that was responsive to their needs. For example, whilst staff were caring and compassionate, we found that people did not always receive appropriate end of life care. Where anticipatory or 'just in case' medicines had been prescribed for end of life care, these were not always used in a timely manner to manage people's symptoms. Similar concerns were raised with us by both nursing staff and an external health care professional. A registered nurse told us, "it's not about not being caring, it's their skills, confidence and lack of knowledge and about being proactive". A health care professional told us that whilst they had generally found that the permanent staff were competent in providing end of life care, they had found that agency nurses could often be reticent at giving 'just in case' medicines even when there was a clinical need.

We could not be confident that people always received appropriate wound care. One person was observed to have a grade two pressure ulcer on the 7 August 2017; however, their skin plan was not updated until the 14 August 2017. No wound care plan was put in place until 14 August 2017. Their skin care plan noted that a 'bed support' should be used to relieve pressure from their toes. This was not in place when we visited the person on the 14 August 2017. We could not be assured that between the 7 and 14 August that this person was receiving appropriate skin care.

A relative told us that staff sometimes tried to wake their family member up for their meal, rather than let them sleep and offer the meal later. This person was receiving end of life care and could be distressed or anxious when awake and so letting them sleep was important. We observed a similar approach. A care worker was asked by a senior to go and wake [the person] for her lunch. This is not person centred care. A more appropriate approach might be to provide meals around people's waking times.

People had not always received care and treatment that was appropriate and met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care).

Our last inspection had identified concerns that people's care plans did not always contain all of the relevant information to support the delivery of responsive and person centred care. Care plans are important documents that describe a person's needs and how these should be met. They assist staff to ensure people's safety and to enable responsive care; this means they are an integral part of the delivery of good care. Whilst this inspection had found that staff had worked hard to make improvements to care plans, further work was needed. We were aware that the progress with improving the care plans had been challenging as twice since our last inspection, the format of the care plans used by the service had been changed by successive new managers. This had created a lot of confusion and additional work for the care and nursing staff. However, despite the ongoing efforts of staff, we continued to find examples, where care plans were inaccurate, not completed fully and not representative of people's changing needs.

People currently at risk of choking, did not have a dysphagia care plan or choking risk assessment. One person who was known to be at risk of choking had inconsistent information recorded in their support plan, and within their room, about their dietary requirements. Whilst the permanent staff displayed a good understanding of the person's correct dietary needs, the service were regularly using agency staff and the incorrect information could increase the risks of the person receiving inappropriate foods. In response to our concerns, the service arranged for an urgent specialist assessment to clarify the person's dietary needs and their records have been amended accordingly. The head of professional practice told us the service was implementing a new choking risk assessment and new dysphagia care plan with an emergency protocol. The training on how to use this documentation was beginning to be rolled out during our inspection and each person with dysphagia would have the new documentations and risk assessments in place within one week.

Diabetic care plans needed to be more robust. One person's diabetic care plan talked of the need to check the person's blood sugar levels 'regularly'. There was no further description as to what was meant by this. Another person's diabetic care plan and room records contained inconsistent information. Their diabetic care plan stated that their blood glucose levels should be within one range, their room record recorded a different range. On one occasion, their blood glucose readings had been recorded as being slightly outside both of these ranges, but it was not clear that any action was taken. We discussed this with the head of professional practice. They advised that the person's diabetes was very stable and that the raised readings were not clinically significant. They agreed to ensure, however, that there was a clearer escalation plan in place. One person's care plan stated that they were living with epilepsy but there was no clear escalation plan in place regarding this need.

Records relating to wound care continued to be inconsistent. Some were well documented in line with best practice guidance. However, in some instances, photographs had been taken of the wound but there was no measurement included in the photograph so it was not possible to ascertain the size or dimension of the wound. Some photographs were not dated. Some care interventions were recorded in the daily notes, others on charts, this inconsistency in recording meant that it was difficult to obtain an accurate overview of the care that had been delivered. When we looked at one person's food diary on the 14 August 2017, it had not been completed since the 11 August 2017. Tools used to assess people's pain were not being consistently used. TMARS were not being consistently completed. Documents recording the daily temperature of the medicines fridge had several gaps each month. Hospital passports were in place but not always up to date or complete. One person's name was consistently spelt incorrectly throughout their care plans. We consistently found assessments that were blank or which were not dated or signed, meaning that it was not clear who had assessed or was accountable for the documentation.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) Good Governance – records.

Care plans continued to consistently lack information about each person's likes and dislikes, their preferred daily routines and about their lives before coming to live at the home. This information is important as it helps staff to engage with the person in a meaningful way. The manager was aware that this was an area which required improvement. Reviews of people's care were completed monthly, but could be better documented to demonstrate more clearly how the person and their relatives had been involved in these.

A range of activities were provided. The service employed one full time and one part time staff member to lead the activities provision within the service. They provided a range of both group and one to one activities which included crosswords, word searches, poetry readings, quizzes, hand and nail care and external entertainers such as singers, speaks on historical subjects and visits by therapy dogs and by other animals.

People could attend a classical music, cookery and or a gardening club and a range of exercise based activities were also offered including Tai-Chi, yoga and movement to music. Important events and birthdays were celebrated. One person told us it was their birthday the next day, they said, "Yes the staff are well aware, we get a fuss made of us, with wine and cake". There was evidence that the activities staff spent time engaging with, and providing activities for people cared for in their rooms.

People told us they were able to express their views and to give feedback about the service. An annual survey had been undertaken with people, the results had been shared with them and where areas for improvement had been identified, the leadership team had identified what actions were being taken to address these. Meetings with people took place regularly and were used as an opportunity for people to make suggestions and to comment on how the service could be improved. One person told us they felt listened to and that recommendations they had made had been actioned such as the positioning of a new elevator. One person had expressed a wish to be introduced to new residents. To address this, plans were in place to provide 'welcome notices' in the library. Relatives told us they were kept well informed and that communication with the home was good. People's relatives and friends were able to visit throughout the day, and we observed them sharing in aspects of their loved ones care.

Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received. People told us they were confident they could raise concerns or complaints and these would be dealt with. One relative told us, "You can always raise concerns, they are on top of everything, it is reassuring".

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager in post. A new manager had been appointed in early July 2017 although they had not as yet applied to register with the CQC.

At the previous inspection the provider was not meeting the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.This was because they had not notified the commission, without delay, of important events which happened within the service. This inspection found that the provider had met the requirements of this regulation.

The provider had not ensured that there were effective systems in place to ensure compliance with the Regulations and to assess, monitor and improve the quality of care provided. Audits were being undertaken but were not being fully effective at driving improvements. We could not be confident that learning from incidents and safeguarding concerns that had occurred over the last year had resulted in improvements within the service so that people might experience consistently high quality care. Investigations undertaken since April 2017 by the head of professional practice into the care of existing and past residents over the last year, found endemic issues with the quality of care provided, with poor record keeping and with some staff not having the skills and knowledge required to meet the more complex needs of some of the people living within the home. Our inspection found similar concerns with each of these areas. Records showed that for some months, care and nursing staff were being reminded of their responsibilities to complete documentation consistently, but that this was still not always happening.

The delay in being able to effectively drive improvements was for a number of reasons which included the ongoing challenges presented by the changes in leadership, high turnover of staff and high agency use. However, we were also concerned that the provider had not maintained sufficient oversight of the service during the previous year in order to be able to reassure themselves of the safety and quality of the service. For example, the quarterly analysis undertaken of incidents and accidents needed to be more robust. The provider had not ensured that a programme of staff supervision and induction had been maintained in the months following our last inspection. The provider information return (PIR) had stated that the provider's representative completed a monthly independent review of all aspects of provision at the home to check that the service was safe, effective, caring , responsive and well led. The use of these reviews was not yet embedded within the service. The provider had been sending the Care Quality Commission regular updates to share the developments with the service and with their progress at achieving compliance. The current leadership team told us, these action plans had not been realistic and had not demonstrated an understanding of the endemic problems within the service which first needed to be addressed before improvements could be made. Whilst the trustees made unannounced visits to the home and met with staff and people using the service, the reports produced of their findings were simplistic and had not made an attempt to measure the progress of the service against the improvement plan and the findings of our previous inspection.

The provider had failed to have effective systems in place to ensure compliance with the Regulations and to assess, monitor and improve the quality of care provided. This was a breach of Regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

It was evident that the new leadership team had developed a good understanding of the challenges facing the service and had begun to implement systems, develop the care plans and provide coaching, mentoring and training to the staff team to improve their confidence, skills and knowledge. Clinical governance meetings were taking place and being used to reflect upon staffing issues, training needs and incidents. During the inspection, a senior team meeting was held to feedback to the team the findings of the analysis of three significant events that had taken place within the service over the last year. We were told that the aim of the meeting was for the staff team to move away from a culture of blame that had been quite destructive within the service and instead learn together and develop best practice to improve the care and support provided. We were advised that the two clinically trained Trustees were to also start attending the clinical governance meetings and that a revised tool had been developed to support the Trustees to undertake robust quality monitoring visits. The recent investigations in incidents, showed a commitment on behalf of the new leadership team to communicate openly and honestly and to admit when the service could have done better.

People told us they had a growing confidence in the new leadership of the service. One person told us, "The home is very well led and managed now…the new manager is very good". Another person told us, "Its really good care, much better than before, especially for my wife since the new management…its gone from good to excellent…the new manager and [head of professional practice] are really on the ball". A health care professional told us, "I do think that the service is now well led. There has been a large turnover in senior staff which was challenging for the home but they now have appropriate staff in place and the service is much better as a result".

Staff also told us that they were beginning to see improvements with the new leadership team. They told us morale was improving. One staff member told us, "The last year has been a rollercoaster, horrendous at times, but it's picking up at the moment". Another staff member said, "Communication is better, things get followed up, it does not get left". A care worker told us the new manager was good, they said, "When she came, she went round, talked with us, she is always smiling, she is very kind with the residents. You can go to her, we are very happy she has come". Another care worker said, "[the leadership team] are going to change things, they listen to your issues and will sort it, it has been hard, we are on our third set of care notes in a year, there are a lot of new staff, its been challenging, but morale is good at present". These sentiments were echoed by a third care worker who told us, "[the manager and head of professional practice] are fantastic, like a mother; together they can make a miracle".

Staff meetings continued to take place periodically and were an opportunity for staff to make suggestions or for the leadership team to share developments with staff and to discuss how the delivery of care could be enhanced. One staff member told us, "I feel well supported; I'm able to say if unhappy about something".

However, these improvements had only really started to gain momentum within the last four months and there was an acknowledgement that much more needed to be done, with many of the planned improvements yet to be in place. To support this, the leadership team had developed a 'Fresh Start Proposal'. The proposal contains a plan for suspending new admissions to the home to allow for a period of time during which the management team can oversee the delivery of a leadership and competency based training programme and embed a reorganisation of how the staff team are structured to support better communication and accountability for the care being provided. It is envisaged that this project will last six months and will include the introduction of a 'Yearling programme', an enhanced induction for new staff and an improved and more robust quality cycle. The project will also include a review by the leadership team and the trustees of the ongoing aims and objectives of the organisation to ensure the training and

leadership support these.

It is key that this improvement project is delivered effectively. A local social care professional told us they would be concerned about the ability of the organisation to implement changes and manage safeguarding concerns if there continued to be ongoing changes in leadership at the home. We share this concern. The ongoing management / organisational changes have had a destabilising effect on staff and at times impacted upon the quality of care people have received. Whilst this inspection has found improvements in some areas, we found further breaches of the legal requirements and overall that the service remained rated as requires improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not always received care and treatment that was appropriate and met their needs. This was a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective systems in place to ensure compliance with the Regulations and to assess, monitor and improve the quality of care provided. This was a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance). Some records were inaccurate, not completed fully and not representative of people's changing needs. This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) Good Governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had been adequately supported to perform their role and responsibilities effectively. This was a breach of

Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).