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

Summary of findings

Overall summary

This inspection took place on 13 and 16 June 2016 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 44 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 complex nursing needs. The Hindson Wing provides general residential and nursing care for up to 29 people. The home does not provide specialist support for people living with dementia or those who might display behaviour which might challenge others.

The service has a number of communal sitting areas, a dining room and 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 service 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 registered manager had left the service the week prior to our inspection. 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. A new manager had been appointed and was due to start at the service in July 2016. In the meantime, the provider's compliance manager was providing management support to the service.

Improvements were needed to ensure that there were at all times sufficient numbers of staff deployed to meet people's needs in a responsive manner. Some people told us they had to wait for support or assistance.

People and their relatives were positive about the care and support they received. Staff knew people well and understood how to meet their individual needs in a person centred way. However, people's records did not consistently contain sufficient information about their needs and how these should be met or about people's preferred daily routines.

Notifications had not always been submitted to Care Quality Commission (CQC) when a significant event occurred.

People's medicines were managed and administered safely, but improvements were needed to ensure

more detailed information was available in relation to when 'as required' medicines should be given and to support the administration of topical medicines and creams.

Where people lacked the mental capacity to make decisions staff had undertaken mental capacity assessments, but these had not always been completed in line with legislation. Plans were in place to address this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations had been applied for.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

Staff had a good understanding of risks to people's health and wellbeing and measures were in place to protect people from risks associated with the environment. People were protected against the risk of abuse and the provider had worked effectively with the local authority to investigate safeguarding concerns.

Staff were supported to carry out their roles and received an induction and ongoing training and supervision.

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

Staff had developed effective working relationships with a number of healthcare professionals to ensure that people received co-ordinated care, treatment and support.

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.

The registered manager had left the service the week before our inspection, but people, their relatives and staff spoke positively about their leadership of the home. The provider was supporting the service until the new manager started in July 2016.

Systems were in place to monitor the quality and safety of the service.

We found two 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

Staffing required improvement to help ensure that people's needs were met in a timely and responsive manner.

Notifications had not always been submitted to Care Quality Commission (CQC) when a significant event occurred.

People's medicines were managed and administered safely, but improvements were needed to ensure more detailed information was available in relation to when 'as required' medicines should be given and to support the administration of topical medicines and creams.

Staff had a good understanding of risks to people's health and wellbeing and measures were in place to protect people from risks associated with the environment. People were protected against the risk of abuse.

Is the service effective?

Good

The service was effective

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.

Staff were supported to carry out their roles and received an induction and on-going training and supervision.

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.

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.

Complaints policies and procedures were in place and information about the complaints policy was available in the service user guide. Complaints had been investigated appropriately.

Is the service well-led?

Good

The service was well led.

The registered manager had left the service the week before our inspection, but people, their relatives and staff spoke positively about their leadership of the home. The provider was supporting the service until the new manager started in July.

Effective systems were in place to monitor the quality and safety of the service.

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 two days on 13 and 16 June 2016. On the first day of our visit, the inspection team consisted of an inspector, an inspection manager, a specialist nurse advisor 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.

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 sixteen people who used the service and two relatives. We also spent time observing aspects of the care and support being delivered. We spoke with the organisations Chief Executive Officer (CEO), compliance manager, a clinical lead, a registered nurse, six care staff, the chef and a member of the activities staff. We reviewed the care records of five people in detail and checked specific elements of the care records for a further three people. We also viewed other records relating to the management of the service 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 was service was in November 2013 when we found no concerns in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Forest Oaks. One person said how staff helped them to feel safe when being hoisted even though they did not like this.

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when an allegation of abuse or a safeguarding incident occurs. The registered manager had failed to inform CQC of one such safeguarding incident. The safeguarding concern had been appropriately reported to the local authority and investigated to ensure remedial actions were put in place to prevent similar incidents; however not ensuring that a notification was sent to CQC is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

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. Information including the contact details of the local safeguarding team was readily available within the home. The provider had worked effectively with the local authority to investigate safeguarding concerns. The provider told us that safeguarding people from harm was discussed in supervision and that the compliance manager was being trained to deliver safeguarding training so that this could be provided in a timely way for new staff. 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 provider. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

We received mixed feedback about the number of staff on each shift. Some people felt staffing was adequate. One person said, "They do everything I need", whilst another said, "Yes I think there is (enough staff)….I'm happy with the time they come". However, some felt additional staff were needed to ensure staff were able to be responsive to their needs. One person said, "The staff are very good, but you do have to wait a long time, they say they are busy, sometimes I have to wait 30 mins, I want to go to the toilet there is nothing I can do". We asked people if they could choose when to get up and when to go to bed. One person said, "Not exactly, I'm still in bed when breakfast comes". Another person said, "I can choose within reason when I go to bed". A third person said, "Staff are on the whole very good, but at night there is a big problem."

During the early shifts (8am – 2pm) there were two registered nurses and eight care workers. After 2pm this reduced to one nurse and five care workers. Night shifts were staffed by one registered nurse and three care workers. There were two clinical lead nurses who were sometimes rostered to provide care but also had supernumerary office hours during which they were able to attend to their management duties such as supervising staff and undertaking audits. We reviewed the rotas for a four week period; these confirmed the home was staffed to these target levels. The provider also employed a team of housekeeping staff, an administrator, chefs and kitchen staff and two activities co-ordinators. There was also a maintenance person.

All of the staff we spoke with told us there was insufficient staff to meet people's needs in a responsive manner. One staff member said, "You have to know who you have to go to quickly, you may have stop in the middle of hoisting. One of us will have to leave to go and answer the call bell and the other will have to stay with the person being hoisted. Some people can be at risk of falls, or [the person] gets very anxious if they can't get to the toilet straight away". A number of staff expressed regret that the staffing levels only allowed them time to attend to people's practical needs. One staff member said, ""They get the care, but you can't do the extra bits". Another care worker said, "They [people] could do with a bit more attention, quality time".

Rotas showed that in the evenings after 8pm, the 29 people on the Hindson Wing were supported by two care workers. The Registered nurse and other care worker were based on the Loriston-Clarke wing. Many of the people on this wing needed two staff to assist with their care needs. Staff told us that whilst the registered nurse was supporting people with their medication, this left one care worker to manage people's needs. They told us this did at times mean a delay in people's needs being met.

Our observations indicated that throughout the morning, staff were constantly engaged in supporting people with their personal care and with the provision of drinks. Staff had very little presence in the communal areas of the home and so it often fell to the activities co-ordinator to provide support and reassurance to those people that were already up and in the communal areas which they did in a very person centred manner; however, this meant they had less time to focus on the provision of activities. On two occasions we were unable to locate a staff member for 10 minutes to support people who were requesting assistance in a communal area.

We could not be confident that staff were currently deployed in a manner that ensured people's needs were met. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Staffing.

We discussed our concerns with the provider. They understood that the numbers of, and how, staff were deployed needed to be reviewed. They planned a detailed review of the homes staffing requirements to ensure that staff were being deployed effectively. They were clear that if this review indicated that more staff were needed then this would be provided. They also planned to introduce a more systematic tool to assist them in determining on-going staffing numbers and ensure these were based on the needs of people using the service and their changing dependency. The previous registered manager had already made arrangements for day staff to start slightly earlier to help ensure there were more staff available to support people at peak times in the morning. Recruitment was also already underway for a fourth care worker at night. These developments once embedded will help to ensure that there are at all times sufficient numbers of staff available to meet people's needs.

People told us they received appropriate support to manage their medicines with many remaining in control of their own medicines. One person said, "The staff order them [medicines] and I manage them". Appropriate systems and processes were in place for obtaining, storing and disposal of people's medicines. Each person had a medicines cabinet in their room which was locked. Excess medicines were stored securely within locked cupboards or refrigerators which were within a locked treatment room. The temperature of all areas used for storing medicines was checked on a daily basis and provided assurance that medicines were stored within their recommended temperature ranges. Controlled drugs were also 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 as there can be a risk of the medicines being misused. The service used electronic medicines administration records (eMARs) stored on a lap top to record the administration of people's medicines. The eMAR included the person's photograph, date of birth and information about any

allergies they might have. The eMARs we viewed had been completed accurately which indicated people were receiving their medicines as prescribed.

Some areas of how medicines were managed required improvement. Whilst some information was available for "as required" (PRN) medicines, this generally only replicated the medicine label and did not provide sufficient personalised guidance for staff about when these should be given. Detailed and personalised PRN protocols help to ensure that all staff, including agency staff, were able to provide a consistent response to people's individual signs of pain particularly where people were no longer able to communicate this. Care workers were responsible for administering prescribed topical creams, but there was a lack of supporting information describing where and how often these creams should be applied. It was not always the staff member who had applied the topical creams whose name was recorded on the eMAR as being responsible for administering the topical medicine. The eMAR was often completed by the registered nurse after confirming with care staff that the cream had been applied. This is not in line with best practice guidance.

A range of risk assessments were used within the service. People had moving and handling risk assessments; falls risk assessments and environmental risk assessments. Equipment was used effectively to manage people's risks. For example, 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 ensured that people had access to a call bell to summon help. One person had a large, touch sensitive, call pad due to their co-ordination problems. Where people were at risk of falling from bed, bed rails were used once appropriate consent and risk assessments had been completed.

One person who was known to be at risk of choking had support plans in place to help minimise this risk. For example, their nutrition plan provided detailed guidance for staff on how they should support the person to eat and drink safely. We observed that staff understood and followed these guidelines. A staff member told us, "We always check [the person's] meal for any lumps and make sure they are sat upright". We did note that this person chose to eat all of their meals in their room, but there was no information about their specific dietary needs readily available in their room or emergency first aid guidance. The service, did at times, use agency staff and this would help to ensure that all staff were informed about the person's dietary risks and were able to provide an effective response in the event of the person experiencing a choking incident.

Screening for the risk of malnutrition was routinely undertaken and a nationally recognised tool was used to assess people's risk of developing skin damage. Handover meetings were conducted every day during which staff shared information about any new risks or concerns about a person's health. Overall, staff had a good understanding of people's risks and how to support them to maintain good health and stay safe, although we did note that where people were losing weight, this information was not always shared with kitchen staff so that the provision of fortified and high calorie diets could be offered. Some of the records used for monitoring people's risks needed to be completed more consistently to ensure that staff were able to identify changes in risk to people's health and wellbeing promptly, enabling them to put appropriate preventative measures in place.

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. The fire risk assessment and fire equipment tests were up to date and staff were trained in fire safety. The provider also 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 February 2016 and had reviewed risks in relation to a range of areas including food safety,

electrical safety, clinical waste and the operation of the lift. Where actions had been required these had been completed or were planned.

Appropriate recruitment checks took place before staff started working at the home. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member 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.

Good

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. A relative told us, "The staff are well trained, I am confident in them". In the recent satisfaction survey, people had rated the overall standard of the care and support they received as either excellent, very good or good.

We looked at how the service met people's nutritional needs. Kitchen staff had information about people's specialist diets including those that required diabetic meals and those that needed soft or pureed food. We were told that a food profile was completed for each resident which included information about their likes and dislikes and where they liked to eat. Most people's dietary risks were assessed and we were able to see evidence that people were usually referred to the GP if staff had concerns about poor dietary intake. Where people were unable to take food orally because of swallowing problems, there were suitable nursing plans in place to support this.

We received mixed feedback from people about the food provided, although most said this was an improving picture since a new catering provider had been arranged. People's comments included, "I have no sense of taste, it's got to look nice and that varies", "Sometimes the meals are good and then not so good…sometimes the soup is cold and the meal can be cold but not often" We noted that where people who chose to eat their meal in their rooms, the hot dessert was served at the same time as their main course, rather than being kept warm on the trolley. A person also said "The food is improving, it wasn't particularly good". The provider was aware that people's satisfaction with the food had been an area of concern and had changed the catering provider to help achieve improvements. They were continuing to monitor this via feedback forms and through the resident meetings.

Hot and cold drinks were readily available throughout the day and people could if they wished have a sherry prior to lunch. At lunch, meals were either served in the dining room, or taken in a hot trolley to each floor before being delivered to people in their room on trays. We observed the lunch time meal on the first day of our inspection which appeared to be a pleasurable and dignified experience for people. Fresh fruit was readily available in the kitchenettes throughout the home which were used by some people to prepare their own breakfast or light snacks.

Staff received appropriate support to perform their role effectively. New staff completed an induction during which they learnt about their role and responsibilities and undertook some essential training. They also spent time shadowing the more experienced staff and reading people's care plans which helped to ensure that they were able to develop their understanding of people's needs. We were told that staff who were new to care were being supported to complete the Care Certificate. The Care Certificate which was introduced in April 2015. The care certificate 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. Agency staff also underwent an induction to the service which included a tour of the home and reading about people's needs and the fire procedures.

Staff had completed training in a range of subjects such as infection control, Mental Capacity Act (MCA)

2005, fire safety, safeguarding, equality and diversity and manual handling training. Where relevant to their role, some staff had completed additional training such caring for wounds or catheter care. Overall staff told us the training provided was adequate to enable them to perform their role effectively and records we viewed showed that this training was generally up to date. Staff held lead roles in areas such as end of life care, falls, and nutrition and wound care which helped to ensure that best practice guidance was shared with the whole staff team. Staff did not currently undertake training in caring for people living with dementia or nutrition and hydration which a number of staff felt would be useful. One member of staff told us, "Dementia training would be useful, we are getting more people with dementia and it would help you to know how to respond". We were told that further improvements to the training programme were planned which would include the introduction of training in these areas. Other improvements were also planned. The leadership team told us they were keen to ensure their senior care workers, now known as associated practitioners were supported to develop their skills and knowledge enabling them to take on more responsibilities in support of the registered nurses. Plans were also in place to implement the Gold Standards Framework (GSF) for patients who were nearing the end of their life. The GSF provide a framework for best practice in relation to end of life care.

Staff received regular supervision and an annual appraisal. Records showed that supervision was used to discuss matters relating to the needs of people using the service, but also the staff member's training needs, any areas for development, and what they were doing well. All of the staff we spoke with told us they received adequate supervision and found this a useful and supportive process. One staff member said, "It's nice to be able to talk problems through". Staff also received an appraisal of their performance which reviewed any training or development needs they might have. The clinical lead told us that the organisation was committed to supporting registered nurses to gain their revalidation and provided opportunities for reflective practice and training. Revalidation is the way in which nurses demonstrate to their professional body that they continue to practice safely and effectively and can therefore remain on the nursing register.

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 or for information about them to be shared with health and social care professionals. We did note that in some cases consent forms were signed by relatives without there being evidence that the relative had legal authority to do so. We observed that staff sought people's consent before providing assistance, for example, we observed staff asking people "Would you like your shoes on today" and "Would you like your tea in this cup or that cup". We heard staff asking one person, "Do you want some more of your banana" and "Can I take this [their plates] away. This helped to ensure that people remained in control of their care and support. One staff member said, "We cannot go against a person's wishes, but if someone was refusing care I would always ensure I told the nurse".

We looked at how the service was implementing the Mental Capacity Act (MCA) 2005. 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, family members and advocates in reaching best interests decisions about how peoples care and support should be provided. 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. We did note that some of the mental capacity assessments viewed had not always been completed correctly. The service had already identified this as an area requiring improvement and plans were in place to introduce a different toolkit to assist staff to more clearly record their assessments of people's capacity.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and were awaiting assessment by the local authority.

Where necessary a range of healthcare professionals including GP's, dentists, physiotherapists, speech and language therapists, and the community learning disabilities team had been involved in planning people's support. Staff attended monthly meetings with the local hospice in order to keep up to date with best practice in relation to end of life care. 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. We were able to see that staff referred people for review by the GP if they were concerned about their dietary intake, following falls or due to showing signs of having chest or urine infections. This helped to ensure that they received co-ordinated care, treatment and support. 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. A visitor told us that they were very happy with their relatives' health care and told us that where there were concerns; staff were always "On the case". A healthcare professional told us, "There are good lead nurses in post who make sensible and appropriate clinical decisions".

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person said the care workers were, "Top of the range, kind, considerate, patient, everything I think a carer should be". Another person told us staff were "Lovely, couldn't be kinder, really go out of their way to be helpful". A third person said, "Tremendous, I like it here". The service had received a number of compliments about how kind and caring staff were, one read, 'There are not enough words to describe the kindness, dedication, professionalism and love you showed'. A relative told us that a key strength of the service was the "Loving care it provided". A staff member said, "It's a lovely place, very friendly….we care really well, it's lovely, I'd come here"! A health care professional told us, "The staff are very caring".

Our observations indicated that staff interacted with people in a kind and caring manner. The atmosphere in the communal areas was good natured and sociable. One person told us, "It's very nice, a nice happy atmosphere". Another person told us, "I'm not a person that gets on with people but the staff are really likeable". Staff spoke fondly about the people they supported and assisted them in a kind and caring manner. A staff member told us, "The staff here care and treat service users as if it's their home and as part of a large family, we see them as an extension of our family, really get to know them, you care for them like you would a member of your own family". People looked relaxed and happy in the company of the staff who throughout our visit appeared jovial, attentive and happy in their work. We observed a staff member help one person who had mislaid an item. The staff member was kind and patient and supported the person in a sensitive manner. A staff member who was responsible for leading the activities spent time with a person who was anxious about a matter. This appeared to help the person become more settled.

Many people living at Forest Oaks were able to understand and make decisions about how their care and support was provided and we saw they were empowered and encouraged to do this on a daily basis. For example, some people chose to manage their own medication. Staff had helped one person to fully understand the extent of their skin damage so that they could make an informed decision about treatment pathways. Another person had been fully involved in discussions with the GP about whether they should be resuscitated in the event that they stopped breathing.

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. One person said, "They [staff] do two things regularly for me, a cup of tea in the evening (I like someone to look in on me) and in the morning help putting on my elastic stockings, otherwise I am independent". They told us that when they had been unwell, they were "Well looked after". 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. One person told us, "I make my own breakfast and have it in my room". 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. Chairs had been placed halfway along corridors to provide resting places for people so that they could continue to walk independently. The importance of promoting people's independence

was also reflected in people's care plans with staff being prompted to ensure they encouraged people to make choices about the clothes they would like to wear and when they got dressed.

People told us they were treated with dignity and respect. 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. Notices were placed on people's doors to create awareness for others that personal care was being provided. This demonstrated that staff were mindful of people's dignity. People told us that staff were respectful of their need for space and privacy on occasion. One person told us, "They leave me alone unless I ring my bell and then they know I really need help!"

People were supported to follow their religious and spiritual beliefs. Songs of Praise gatherings were held and the local vicar visiting 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. Not everybody had this in place as yet as this is a work in progress.

Requires Improvement

Is the service responsive?

Our findings

Most people told us their complaints or concerns were taken seriously and that their views were listened to. People told us they could write feedback forms and were invited to regular residents meetings. One person said, "One person I know has written [a complaint] and it's leading to action". People were also supported to take part in social activities which they told us enjoyable. One person said, "Yoga, I love Yoga, sometimes I go to tai chi but I like yoga best". Another person said, "I went to the Queens party here, it was good".

Many of the staff working at Forest Oaks had been with the service for many years. This had enabled them to develop a good understanding of people's individual wishes about how their care should be provided. Staff were able to give us examples of people's likes and dislikes which demonstrated that they knew them well. For example, staff knew which people preferred custard with their desserts and how they liked their drinks. Staff knew which people loved animals and enjoyed visits from the therapy pets. A staff member told us that visits from the therapy pets made one person 'come alive'. The clinical lead was able to describe how one person with poor communication showed they were in pain. Staff knew which people's calls bell they needed to respond to immediately to prevent the risk of harm or injury. They were able to tell us which people needed repositioning regularly and those for whom they needed to encourage food and fluids. People and their relatives told us that staff were good at recognising and responding to changes in their health care needs. We observed a handover during which staff shared information about how people had been and about their dietary intake and skin condition. We were able to see that health care professionals were consulted on a regular basis helping to ensure that people's healthcare needs were generally well managed.

However, whilst the staff we spoke with appeared to have a good understanding of people's needs and wishes, their care records did not always contain all of the relevant information to support the delivery of responsive and person centred care. We looked at the care plans and associated records for eight people during this inspection. Whilst the care plans generally reflected people's current needs, there were areas where they could be improved, some of which could have implications for people's care and welfare, particularly if they were being supported by agency or less experienced staff. We found examples where there was a lack of guidance for staff about matters such as behaviour management and the treatment of diabetes. For example, the diabetic care plans for one person with insulin dependent diabetes stated that the goal was to 'ensure sugar levels were within normal limits' but did not state what normal limits were for this person. The plan did not include a clear escalation plan which described the action that should be taken if their blood sugar levels were outside of safe parameters. Escalation plans are important as they help staff to provide appropriate interventions and also assist them to recognise and respond to changes in people's health. One person was living with dementia. Their care plan stated that their behaviour could change quickly and be unpredictable. The care plan did not however provide any guidance for staff on how they might respond to these behavioural changes.

Records relating to wound care were 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 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. Food and repositioning charts were found to be completed fully.

Some risk assessments had not always been updated when people's needs changed. For example, one person's falls risk assessment had not been updated for two months despite them having experienced two falls in this period. Another person's records stated that they should have monthly assessments of their risk of developing skin damage. However, these monthly reviews had not taken place between June 2015 and December 2015. Post-falls observations had not always been recorded in line with the frequency determined by the service. We noted that daily records were completed but these were quite task orientated and not focused on the person's experiences of their care. Elements of the handover form we were given were also out of date and did not reflect people's current needs.

Care plans lacked 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. Reviews of people's care could be better documented to demonstrate more clearly how the person and their relatives had been involved in these. Improvements were needed to ensure people's care records, contained all of the relevant information to support the delivery of responsive and person centred care.

A range of activities were provided. The service employed two people to lead the activities provision within the service. They provided a range of both group and one to one activities for people living at the home. A schedule of activities was advertised and included crosswords, word searches quizzes, flower arranging, hand and nail care and external entertainers. People could attend a classical music or a gardening group who took the lead on making decisions about what to plant in the home's garden. A range of exercise based activities were also offered including Tai-Chi, yoga and movement to music. People were also supported to take trips into the village for shopping or attend their own hairdresser. One person told us, "I go to the Tai Chi, seated yoga and movement to music, also there is singing and music things that I go to, not so long ago we had a wedding here and they laid on a very good reception for the couple". Weekly records were kept of the activities that each person took part and these showed that people cared for in their rooms also received some opportunities for one to one interaction with staff.

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. We saw that people were being consulted on the fabric for new furniture. One person told us, "We have six weekly meetings and we get a copy of the minutes, We get things off our chest and they tell us what's happening".

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. For example, we saw relatives sharing a meal with their family member. One person told us, "If you have a visitor, they [the staff] always bring a cup of tea if I ask". There was guest accommodation on

site that family members could use when visiting their relatives, if for example they lived some distance away.

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 person said, "I'd probably go the deputy or the manager, if it was more general I would write a resident feedback form and post it". Records showed complaints or comments were used as opportunities for learning or improvement and where necessary remedial actions were put in place to prevent similar incidents from occurring again.

Good

Is the service well-led?

Our findings

The registered manager had left the service the week before our inspection, but people, their relatives and staff spoke positively about their leadership of the home. Comments included, "[The registered manager] was a very good manager" and "We miss them". A staff member told us, "They [the registered manager were brilliant, so supportive, I'm so sad they have left". A new manager had been appointed and was due to start at the service in July 2016 and had already spent some time in the service meeting people and their relatives. In the interim, the service was being managed by the provider's compliance manager.

Staff told us that the service was a good place to work and that they enjoyed their job. One staff member said, "This is the best job I have ever had, it means a great deal to me working here". Another staff member said, "The staff all get on very well…we work well with the nurses". Following the departure of the registered manager, some staff told us that morale was a little low and they expressed some anxiety that there was going to be a period of change. Most of the staff were also concerned about the staffing levels and were keen that be reviewed in light of the increasing dependency of the people they were caring for. We spoke with the provider and compliance manager about this. They advised that staff would continue to be consulted and supported by the management team. They advised that staff were encouraged to approach them at any time with issues and each month the human resources manager held an open door forum with staff to ensure they had an opportunity to discuss any concerns. Staff meetings also took place periodically. These meetings were used to share developments with staff and to discuss how the delivery of care could be enhanced.

The provider had appointed a compliance manager who was responsible for ensuring that there were effective systems in place to monitor the effectiveness of the service and to identify any potential risks or shortfalls that might compromise its quality and safety. They undertook audits of the service and produced clear actions plans as a result of these. Incident and accidents were monitored by the provider and we were able to see that they maintained a record of the actions taken in response to mitigate any risks and prevent reoccurrences. Clinical governance meetings were used to reflect upon incidents that had taken place both within the service and in other settings so that staff could learn from these events and improve the safety of people using the service. For example, products used to thicken drinks for people who had swallowing problems were now locked away to prevent the risk of people accidentally ingesting these causing asphyxiation.

Audits were undertaken of areas including care documentation, infection control, wound management, bed rails and medicines management. Where areas requiring improvement were identified, an action plan had been drafted which included who would be responsible for ensuring improvements were completed. We did note that whilst care plans audits were undertaken, these had not identified the issues we found in relation to people's records, these could therefore be used more effectively to help ensure that care plans are a fully robust and person centred record of people's needs and wishes. The home manager submitted a weekly report to the provider which looked at issues such as the number of agency staff that had been required, safeguarding incidents, complaints, medicines errors and pressure ulcers. This helped to ensure that the provider remained informed about issues or concerns relating to the service. The trustees made regular

unannounced visits to the home and met with staff and people using the service. They produced a report of their findings and where necessary took prompt action to drive improvements regarding the quality and the safety of the service. For example, on a recent visit they had identified that the internal telephones presented issues when communicating during fire drills. In response portable two way radios had been purchased.

The provider had a good understanding of the challenges facing the service. Throughout the inspection, where people and staff told us about areas of the service that could improve, many of these had already been identified by the provider and plans were in place to address these. For example, The provider had taken action to make improvements to the food provided within the service. Changes were planned to the paperwork used for recording mental capacity assessments and a staffing review was underway to help ensure that sufficient numbers of staff were deployed at all times to meet people's needs.

The provider had a vision for the service. They were committed to developing the service to ensure there remained a strong person centred culture within the home. They had engaged an external consultant to assist in developing the care plans to ensure these were more person-centred. The provider was also reviewing their organisational and workforce values. Suggested organisational values included promoting independence, supporting choice, privacy, dignity and fulfilment. Throughout the inspection, we saw that staff worked and interacted with people and visitors in a manner that was in keeping with these values. The provider was developing a service user guide with contained lots of useful information including how people might access advocacy and local clubs and organisations. Plans were also in place to embrace the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. The provider was keen to develop a team of volunteers and encourage relatives to get involved and join the organisation's board so that they could be involved in steering the future direction of the service.

The provider told us they were proud of the staff team who they said "Delivered really good care…they know the residents really well and all the little things they do without thinking about it…the reception staff are brilliant too". The provider hoped to get people using the service involved in nominating 'Employee of the Month' to recognise the contribution of staff to the service. The provider was also proud of how the service was part of the local community which was echoed by one of the visitors we spoke with who said, "The strength of this service is the way it fits in the community, the community feels it owns the home and spends time here visiting friends and acquaintances".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to report a safeguarding incident to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably deployed to ensure people's needs were always met in a responsive manner.