Barchester Healthcare Homes Limited

Forest Care Centre

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 responsive?	Good

Overall summary

When we carried out an unannounced comprehensive inspection of this service on 03 and 04 March 2015 breaches of legal requirements were found. We took enforcement action against the provider in relation to regulation 9, 10 and11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These relate to regulation 12. 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found other breaches of regulation but we did not follow these up at this focused inspection as they will be followed up at a later date.

We undertook this focused inspection to check that the provider had made improvements to ensure people were safeguarded from abuse. We also examined the processes for assessing people's needs to protect them from receiving care or treatment that was inappropriate or unsafe. This report only covers our findings in relation to the aforementioned requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Forest Care Centre on our website at www.cqc.org.uk.

The service did not have a registered manager in place but an acting manager was available who had been in post for approximately six weeks. 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.

Summary of findings

At this inspection we found improvements had been made in relation to safeguarding people from abuse as they were no longer exposed to inappropriate methods of restraint.

People were protected against the risk of psychological ill treatment and punitive measures to control behaviour was no longer used.

Procedures had been amended to ensure people could maintain their skin integrity and people would receive medical interventions in a timely manner in the event of a medical emergency.

People could be assured their risk of falls would be assessed and fall prevention strategies would be put in place.

Systems were also in place to analyse clinical incidents, such as falls, and information was shared in line with multi-agency safeguarding procedures.

People were in receipt of the required one to one support so staff could be responsive to people's individual needs. People could participate in meaningful and stimulating activities.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Action had been taken to improve the safety of people and they were safe as they were no longer exposed to inappropriate methods of restraint.

People were protected against the risk of psychological ill treatment and punitive measures to control behaviour was no longer used.

Requires improvement

Is the service effective?
Staff had received training in appropriate restraint techniques.

People's care plans had been amended and all mention of physical restraint techniques had been removed to ensure staff only used therapeutic approaches to manage challenging behaviours.

Requires improvement

Is the service responsive?
Systems were in place to aid people to maintain their skin integrity and to ensure people received medical interventions in an emergency.

People could be assured their risk of falls would be assessed and fall prevention strategies would be put in place.

People were in receipt of the required one to one support so staff could be responsive to their individual needs. People could participate in meaningful and stimulating activities.

Good

Forest Care Centre

Detailed findings

Background to this inspection

We undertook an unannounced comprehensive inspection of Forest Care Centre on 03 and 04 March 2015. At that time we found the provider was not meeting legal requirements and we took action against them by serving a warning notice which told them they must make improvements by 10 April 2015. This unannounced inspection was undertaken on 22 April 2015 to check that improvements to meet legal requirements planned by the provider after our previous inspection had been achieved.

The team inspected the service against three of the five questions we ask about services: is the service safe, effective and responsive. This is because the service was not meeting these legal requirements. We will follow up and report on other improvements we asked the provider to make at a later date.

The inspection was undertaken by one inspector. During our inspection we spoke with seven members of staff, the acting manager and the area manager. We also looked at the care records of four people who used the service to establish how people's skin integrity was monitored and what procedures had been put in place to maintain people's skin integrity. We looked at the revised processes to ensure people received a timely response to any health care emergencies and if referrals had been made to specialists to seek advice and guidance. We also observed interactions between staff and people who used the service.

Requires improvement

Is the service safe?

Our findings

When we inspected the service on 03 and 04 March 2015 we had concerns as people were being put at risk because staff were not adhering to the organisation's policies and procedures relating to restraint. They were using a type of restraint entitled General Services Assessment Technique (GSAT) which we were told by members of the management team to be inappropriate within a nursing home setting.

At that inspection we found the provider's restraint policy stated that therapeutic approaches should have been used in the nursing home to minimise risk when people had exhibited behaviours that put them, or others at risk. Our observations showed that these instructions were not being put into practice as staff were containing behaviour and reacting to incidents rather than being proactive in preventing them from happening. We also found a lack of individual restraint records to monitor the frequency of restraint. Therefore a post incident analysis and evaluation process to determine if the restraint was appropriate, proportionate and justifiable could not be undertaken.

At this inspection we looked at how people's challenging behaviour was managed and monitored. Overall we found improvements had been made and the warning notice was met.

People could be assured they were not exposed to inappropriate methods of restraint. We found staff were aware of the need to be proactive in preventing incidents from happening and they told us that the use of the revised techniques had resulted in a significant drop in challenging behaviour. Throughout our inspection we did not observe any incidents where restraint was required and saw staff were incorporating therapeutic approaches when required such as gardening, manicure sessions and taking strolls with staff in the garden area.

The acting manager was able to show us that effective systems for monitoring the frequency of significant incidents within the home such as restraint had been established. We found these would be effective in identifying and initiating strategies to minimise similar incidents happening again. The process would also ensure appropriate assessment could take place following these incidents to consider what actions were needed to protect the person from being placed at further risk of harm such as referrals to the safeguarding adult's team.

We found that all staff were aware of the importance of reporting significant incidents, including any of abuse to the acting manager so they could report issues in line with multi agency safeguarding procedures. Records showed that one incident of a serious nature had occurred since our previous inspection, and we found this had been referred to the local safeguarding team.

The acting manager described an incident where a person had experienced a fall. We found this incident had been reported to them in a timely manner. As a result of the increased effectiveness in the reporting procedures the acting manager was in a position to undertake an analysis of the circumstances of the fall and initiate actions to minimise the risks to the person of additional falls.

When we inspected the service on 03 and 04 March 2015 we had concerns as people were not protected against the risk of psychological ill treatment. We found punitive measures to control behaviour that challenged was used and that staff had felt this was acceptable practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This relates to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the acting manager told us that the practice of using punitive measure had stopped. This information was confirmed by staff. They told us they had attended meetings where the practice had been discussed and had immediately stopped. We also established that an on-going training programme relating to the safeguarding of vulnerable adults had been initiated to ensure staff were fully aware that using punitive measures to control behaviour was not acceptable.

Requires improvement

Is the service effective?

Our findings

When we inspected the service on 03 and 04 March 2015 we had concerns as staff were not completing records to identify issues which increased people's behaviour that challenged therefore effective strategies could not be formulated to minimise such behaviour happening. Furthermore people were not always protected from avoidable harm as an analysis of incidents had not been undertaken. We also found that information about the incidents had not been shared in line with multi-agency safeguarding procedures. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This relates to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that effective monitoring systems were being adhered to. We found that improvements had been made and the warning notice was met.

We found records of all incidents were being entered into the organisation's clinical governance systems as soon as the incident had occurred. This was to ensure the acting manager could identify trends and themes which could increase people exhibiting behaviours that may challenge.

When we inspected the service on 03 and 04 March 2015 we had concerns as staff had received training in General Services Assessment Technique (GSAT) which was a restraint technique which was inappropriate for this location.

At this inspection the acting manager told us that the use of GSAT had been stopped within the nursing home setting.

We were also informed by the acting manager that all staff had attended training in an alternative behaviour management approach, the Management of Actual or Potential Aggression (MAPA) This was designed to enable staff to safely disengage from situations that presented risks to themselves, the person receiving care, or others. This information was confirmed by all staff spoken with on the day of our inspection.

We also found that as a result of a recent review of people's care plans all mention of physical restraint techniques had been removed. We saw people's care plans now contained information to inform staff that therapeutic approaches should only be used to minimise the risk associated with challenging behaviours. Records also highlight triggers which could initiate challenging behaviours and stated that activities and distraction techniques were to be utilised to de-escalate situations where people exhibited aggression and agitation. Through our inspection we saw staff interacting with people in a relaxed manner and were adhering to information within the care plans. We did not observe any inappropriate restraint being used.

We found care plans had been amended to ensure procedures were in place to protect people who were vulnerable to abuse. We found the care plans now provided staff with good information on how to ensure people were no longer placed in a vulnerable situation. They stipulated that formal one to one supervision was to be provided to inhibit the likelihood of negative incidents happening between people. Throughout our inspection we saw staff were adhering to the care plans and the one to one supervision was being provided in a therapeutic manner.

Good

Is the service responsive?

Our findings

When we inspected the service on 03 and 04 March 2015 we had concerns that people who had been assessed as "at risk of pressure ulcer formation" and had not had preventative strategies put in place to minimise the risk. At that time we also established people had experienced delayed responses to health emergencies. We also found that referrals to specialist falls preventions teams and diabetes management specialist had not always been undertaken in a timely manner.

At this inspection we found every person residing at the home had undergone a risk assessment to determine their risk of developing a pressure ulcer. Whilst no one was reported to have pressure ulcers at the time of our inspection we found practices associated with pressure ulcer prevention had improved. We found a tissue viability care plan was now in place in all the care files examined. These had been reviewed to ensure they remained up to date. We also found that systems were in place to ensure people's weight was checked at appropriate intervals as weight loss has been shown to be a contributing factor to pressure ulcer formation. This shows that people could be assured that systems were in place to aid them to maintain their skin integrity.

People could be assured that they would receive medical interventions in a timely manner in the event of a medical emergency. The acting manager told us there had been three admissions to hospital since our last inspection. Records showed that people had attended hospital in a timely manner and did not experience any delays. Staff confirmed this information. One member of staff told us, "We have the staff now to go with people to hospital if needed," whilst another member of staff said, "It's not a problem if we need to go on appointments, we now have enough staff."

People could be assured that their risk of falls would be assessed and preventative strategies could be planned. Records showed that all of the people residing at the home had been fully reviewed to determine their falls risks. Where people had been identified as at risk of falls, referrals had been made to the specialist in this area to seek advice to minimise the falls risk. We also found that the acting manager had initiated systems to ensure all falls would be reported to them on a daily basis so they could record when people fell and initiate strategies to minimise the risk

People could be assured that they could attend appointments with health care professionals. We looked at a variety of records and found people had attended appointments at the local hospital and had received diabetic eye screening opportunities. As a result of the screening process the person had also attended consultations with ophthalmic specialists. We also found that care plans for specific complications associated with diabetic retinopathy were in place which were backed up by research based information. Records also showed that people had received interventions from their general practitioners (GPs) when required. Records showed GPs had provided advice on the management of diabetes such as the provision of random blood glucose monitoring and this advice was being put into practice.

When we inspected the service on 03 and 04 March 2015 we had concerns as a person had their one to one support discontinued without an effective assessment being undertaken. We also had concerns as people were not provided with the opportunity to participate in meaningful activities to stimulate them in an attempt to inhibit behaviour that challenged.

At this inspection we found that people were in receipt of the required one to one support and could participate in meaningful and stimulating activities. Overall we found sufficient improvements had been made and the warning notice was met.

People received one to one support when required. The acting manager told us that where people had been assessed as needing one to one support to maintain their safety, and the safety of others, the support was now being provided. This information was confirmed by several members of staff. They told us they now felt able to provide the one to one support and they confirmed that an increase in staffing levels had been a contributory factor in improving their ability to monitor and support people. One member of staff told us, "We are always able to provide the one to one support that people need. It's much better here and things have improved over the last few weeks. The staffing levels are much better." Another member of staff, who we observed to be standing outside a person's closed bedroom door said, "I am providing one to one support at the moment, even though they (person who used the service) is still in bed, which is their choice, I am still required to provide the one to one monitoring."

Good

Is the service responsive?

People could be assured they could participate in a varied social activities programme. At this inspection the acting manager told us a revised programme of social activities had been planned and were happening on a daily basis. This was confirmed by members of staff who told us the activities now consisted of pamper sessions, going to the in house café facility or having trips into the local community to go to local shops, parks and the cinema. We found people's activities were recorded in their records and an activities board had been purchased. This was in the process of being mounted in the home to highlight what activities aware happening and when.