The Wilson Crawford Partnership

Forde Park Care

Inspection report

6-7 Forde Park
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Inadequate

Overall summary

Forde Park Care consists of two homes located along the same road. One home provides accommodation for up to 11 people and the other provides accommodation and nursing care for up to 43 people. The home provides care for older people and people living with dementia or mental health needs. This inspection was unannounced and took place on 7, 8 and 12 May 2015. Two adult social care inspectors took part in this inspection. At the time of our inspection there were 44 people using the service in total and there was a registered manager in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection took place in August 2013. At that time we found the service was not meeting the regulations in relation to records. We set a compliance action and told the provider they needed to make improvements. The

Summary of findings

provider sent us an action plan telling us what they were going to do to meet the regulation. On this visit we checked and found that the required improvements had not been made.

People were not always being protected from risks associated with their care and treatment. People were not being repositioned on a regular basis and according to their needs. People were not receiving the fluids or nutrition they required. People were not always being transferred using the appropriate moving and handling techniques. People did not always receive the care identified in their care plan. Records were not well maintained.

People were not protected against the risks associated with medicines, as some prescribed creams had not been ordered, staff had been applying creams to some people that were prescribed for others.

Staff had not always received supervisions or appraisals. Staff did not always demonstrate a caring attitude towards people they were supporting and people were not always respected by staff.

Adequate systems were not in place to assess, monitor and improve the quality and the safety of services provided.

People benefitted from some activities on offer. People were being protected from abuse. Staff had received training in what to do to raise concerns about possible abuse. There were enough staff on duty to support people, and staff had the skills and knowledge to support people with their care. Staff understood people's rights under the Mental Capacity Act 2005 and in relation to depriving people of their liberty. People had access to healthcare services that met their needs. Staff knew people well. People benefitted from a clear complaints procedure which was on display in the home.

We found a number of breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The service was not always safe.

People did not always receive their prescribed medicines and systems in place for managing medicines were not sufficiently robust.

Risks identified had not been appropriately managed.

People were being protected from abuse, and there were enough staff on duty to support people and meet their care needs.

People were protected from unsuitable staff because staff recruitment checks had been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive supervisions or appraisals.

People did not always receive the adequate amount of fluid required to maintain their health and wellbeing. Food charts were not correctly maintained to ensure people were receiving the correct amount of nutrition.

Staff received comprehensive training.

Staff understood people's rights under the Mental Capacity Act 2005 and in relation to depriving people of their liberty.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff who treated them with dignity and respect.

People and their relatives told us they were pleased with the staff who supported them and the care they received.

Staff involved people in maintaining their independence.

Is the service responsive?

Good

The service was responsive.

People's needs were clearly identified in their care plan.

People benefitted from activities on offer and staff worked to minimise the risk of people becoming isolated.

People benefitted from a clear complaints management process and felt confident their complaints would be appropriately responded to.

Summary of findings

Is the service well-led?

Inadequate 

The home was not always well led.

Issues identified during our previous inspection had not been rectified.

Records were not always well maintained and updated.

Staff were not adequately supervised which meant the management were unable to ensure people were getting the care they needed or were being treated with respect and dignity.

The systems in place relating to quality assurance were inadequate and had not identified some significant concerns.

People benefitted from an approachable management team who gained people's feedback and acted on it.

Forde Park Care

Detailed findings

Background to this inspection

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

This inspection visit took place on 7, 8, 12 May 2015 and was unannounced. This inspection was carried out by one adult social care inspector on 7, 8 May 2015 and two adult social care inspectors on 12 May 2015. Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us.

During the inspection we spoke with the registered manager, the deputy manager, the day to day lead (in charge of the residential home), six nursing and care staff members and the chef. We spoke with two visiting GPs, an external training coordinator and two healthcare assessors.

We spoke with four people who lived at Forde Park Care. Most people who lived in the nursing home were unable to verbally communicate with us. We also spoke with ten relatives who visited during the inspection. Some of the people who lived at the home were not able to share their experiences with us as they were living with significant dementia. During the inspection we used the Short Observational Framework for Inspection, or SOFI. SOFI is a specific way of observing care to help us understand the experience of people who could not communicate verbally with us.

We looked in detail at the care provided to seven people, including looking at their care files and other records. We looked at the recruitment and training files for four staff members and other records in relation to the operation of the home such as risk assessments, policies and procedures.

Inadequate

Is the service safe?

Our findings

The home was not always safe. People were not always protected from risks presented by medicines. We identified concerns with people not always receiving the care they required in order to prevent them from developing or healing from pressure sores and people's health not always being appropriately monitored.

People were not protected against risks because risk management plans in place, were not always followed. Five care plans we looked at related to people who had been assessed by staff as being at risk of developing pressure ulcers, or had developed pressure ulcers. Due to these risks they had been prescribed creams to be applied to their skin. We found that records showed these creams had not been applied as prescribed. There were a high number of occasions where the creams had not been applied at all and others where the creams had been applied less frequently than prescribed.

Risks to people's welfare were not always well managed to keep them safe from avoidable harm. For example, some people required regular repositioning in order to manage the risk of developing pressure damage. One person's risk assessment identified that they required repositioning every two hours due to a severe pressure ulcer. According to the records there were periods when they had not been repositioned for up to seven and a half hours. Records showed that this person also required their pressure ulcer to be cleaned daily with saline solution. Records did not show that this had not taken place on a number of occasions. Staff had recorded that one person required repositioning every four hours in order to keep them safe from developing pressure sores. Records showed they had not been repositioned on one occasion for 28 hours. We spoke with a senior member of staff who told us they had concerns this person had not received the care instructed in their care plan due to specific staff members not delivering appropriate care. They told us disciplinary processes were underway in order to tackle this issue.

Staff had identified that some people were at risk of becoming malnourished and or developing pressure sores. Risk assessments were available for staff to use to determine the level of risk and to provide strategies for managing those risks. Records showed that these had not always been completed, or reviewed in line with the risk management processes in place. People had not had their observations, such as blood pressure and pulse, recorded regularly, although it stated in their care plans that these should be completed. This means that instructions set out in care plans were not being completed.

One person had diabetes and had a management plan in to place to help keep them safe. Staff were instructed by the person's GP to measure the person's blood sugar levels which should be maintained between limits set by the doctor. Records over the preceding two months showed that the blood sugar regularly fell below the set limit. Staff had not taken action in relation to this. Although the person's blood sugar levels very rarely fell between the limits set by the doctor no new risk assessments or specific care plans had been drawn up in order to address this. There was no guidance about what steps staff should take in order to increase this person's blood sugar levels in order for them to fall within the limits set by the doctor. This person was not protected against risks associated with their blood sugar levels as the service had not taken appropriate steps to mitigate these risks.

During our inspection we saw one person being moved by two care staff. They used an underarm lift, which is poor practice and put the person at risk of avoidable harm.

People's medicines were not well managed. One person's prescribed topical medicines had not been ordered by the service and staff had been applying medicinal creams which had been prescribed to someone else. This means the service had not ensured there were sufficient quantities of this person's prescribed medicines to meet their needs and had applied a topical medicine the person was not prescribed.

We checked the amount of some of the medicines in stock, against records relating to these medicines. Records did not match stock and showed that some medicines appeared to be missing. The record book did not give a reason for this medicine to be absent and there was no record of it in the destroyed or returned record book. This means people were put at risk due to the unsafe management of medicines. The Medication Administration Record (MAR) belonging to the nursing home contained a number of gaps where it appeared the medicine had not been administered and the reason for this had not been recorded.

Inadequate

Is the service safe?

This was a breach of Regulation 12 (1) (2) (b) (f) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff understood how the systems for the safe administration of medicines worked and had received appropriate training and assessments of competency. Information was available within each care plan about the medicines people required. A medicines audit had been carried out at the residential home and the systems in place relating to medicines at that home were robust. Medication Administration Record (MAR) sheets belonging to the residential home were appropriately completed. We observed staff dispensing medicines in the nursing home and found correct procedures were followed. People were told what medicine they were taking, what it was for, and were given time to take it at their own pace. There were clear instructions for staff regarding administration of medicines where there were particular prescribing instructions. Best interest decisions had been made following assessments of capacity where people were no longer able to make decisions about taking their own medicines.

People were protected from the risk of abuse as staff had undertaken training in safeguarding. Staff understood what to do if they identified concerns and felt comfortable raising any concerns. We looked at the service's safeguarding policy as well as their whistleblowing policy. We saw details of external agencies to be contacted and their contact details.

Accidents and incidents were recorded under each person's name in order to better analyse patterns of falls or incidents relating to particular individuals.

There were sufficient staff on duty to keep people safe and meet their needs. People told us there were enough staff on duty and they were happy with the staff. We observed staff responding to people's needs, assisting people with eating and drinking and responding to call bells. People were protected from the risk of unsuitable staff because the service had appropriate recruitment systems in place. The service had taken steps to ensure staff were of good character, had appropriate skills, knowledge and qualifications to carry out their role.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

Some people needed support with eating and drinking, and did not always receive this in a way that met their needs. Staff had assessed one person as needing 2100ml of fluid a day. According to their fluid chart the most fluid they had taken in a day was 1350ml and the least was 940ml. Another person who had also been assessed as requiring to drink 2100ml of fluid a day had taken a maximum of 1140ml and a minimum of 620ml a day. Records showed that these people had not been taking in the amount of fluid they had been assessed as needing.

One person had diabetes. It is particularly important for people with diabetes to have sufficient amounts to eat in order to maintain their blood sugar levels. Records showed that this person had, on occasion, only eaten breakfast. Staff told us this person enjoyed their food and ate well, however their blood sugar levels did not reflect this and were regularly lower than the levels advised by the doctor. This person was prescribed regular insulin injections and therefore their health and wellbeing was at risk due to receiving insufficient nutrition.

This was a breach of Regulation 14 (1) (2) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff did not always receive supervisions or appraisals to monitor and evaluate their performance. The provider had identified this as an area for improvement in the information provided to us prior to this inspection. Plans were in place to address this. Staff told us they had not received regular supervisions. The supervisions and appraisal folder showed most staff had only received one supervision per year and no formal appraisal. The registered manager and the deputy manager told us the systems in place at the time of our inspection to supervise and appraise staff competence were not adequate. They told us staff were not appropriately supervised in relation to completing records and they were unable to ensure themselves that staff were delivering all of people's identified care needs. They told us about the processes they were putting in place to rectify this, however at the time of our inspection these plans had not yet been implemented. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff received appropriate training to ensure they had the skills to carry out their work. Staff took part in an induction programme when they started work and shadowed a more senior member of staff until they were confident to work on their own. People told us they felt staff were competent in their roles. Staff told us they had received adequate training and they were able to request further training if they wanted it. Staff said "If I want more training I can ask for it", "They offer lots of training, if there's any training I need they give it" and confirmed the service encouraged them to take on further relevant qualifications.

Some people living at Forde Park did not have the capacity to make some decisions. Staff understood people's rights under the Mental Capacity Act 2005 (MCA) and in relation to depriving people of their liberty. The provider was meeting the requirements of the MCA. Staff had received appropriate training and could demonstrate a good understanding of the issues around capacity and consent. Staff told us how they would offer people options and ask them for their permission before delivering care regardless of their mental capacity. There was very clear guidance in the care plans around obtaining people's consent and the different ways in which people expressed their consent. Capacity assessments and best interest decisions had been undertaken and recorded for different areas of people's care, such as personal care or administration of medicines. Appropriate applications had been made with regard to the Deprivation of Liberty Safeguards (DoLS), which is where an application can be made to lawfully deprive a person of their liberty in their best interest or for their safety, and where the person lacks capacity.

People told us they were happy with the food at the service. One person said, "If there's something I don't like for food they will get me something else". The food was prepared from a kitchen located between both homes. The food was of good quality and contained fresh fruits and vegetables. The service had obtained people's likes and dislikes regarding food and drink and these were appropriately recorded. Care plans also contained information about people's preferred cutlery and good details around people's eating habits and preferences. People who could make choices were asked what they wanted for their meals. They were provided with options and could make specific requests. We saw people ask for

Requires Improvement

Is the service effective?

their main meal to be served without peas for example. We observed two people being assisted with their lunch and saw staff were patient with them, told them about the food they were eating and used appropriate cutlery.

People had access to appropriate healthcare services and had been referred to speech and language therapists, dieticians, GPs, chiropodists, physiotherapists, dental and optical services as necessary. We spoke with two visiting GPs who told us the service was very pro active when it came to seeking advice and asking for professional input into people's care.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring.

People were not always supported by staff who treated them with dignity and respect. During our inspection we observed people sitting in the upstairs lounge of the nursing home. We observed staff talking about a person's continence at loud volume despite the person in question being in the room, as well as a number of other people. Staff also discussed this person's behaviours and their mobility in derogatory terms, for example referring to her as not being a 'complainer', at loud volume whilst they, and others, were in the room. We also observed staff speaking at loud volume to each other across the room on many occasions, despite there being a number of people sleeping in the room. This is a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were very positive about the care they received and told us they felt respected by staff. Relatives said "The staff are respectful. They speak to 'my relative' well". Staff told us they respected people and maintained their dignity at all times, however this was not the case during our observation. The service had created signs on people's doors which stated when personal care was being delivered in order for their privacy and dignity to be maintained during these times. Care plans detailed how to maintain people's dignity and privacy and reminded staff to shut doors and close curtains when providing people with personal care. We observed staff treating people with respect, whilst inspecting the residential home, and speaking to people in an encouraging and supportive way.

It was clear in the residential home that staff knew people well and were supportive in the manner in which they spoke with and cared for them. In the nursing home staff were assigned to work on specific floors and therefore knew the people who lived on those particular floors well but did not know the people who lived on different floors. This could cause issues when people from different floors attended activities together or when there were staff shortages which meant staff worked on a different floor than they had previously been used to. This issue had been raised by staff and this was in the process of being changed.

People and their relatives were pleased with the staff who supported them and the care they received. People said "The staff are very good. I feel looked after. They'll come in and talk to me". Relatives said "They're all helpful. They go out of their way to help. Nothing is too much trouble", "They are very attentive. They are calm, they make eye contact, they get down on 'my relative's' level, they explain things to 'my relative'. I would describe the home as caring"; "They gave 'my relative' an eater egg at Easter. Everyone got one. They didn't have to do that. I feel happy with the staff here. They've been very good". Staff told us they cared for people well and said "I think it's highly person centred care. I'm happy with the care. I think people are happy here. We have staff who are very caring", "Staff do a lot of chatting with people, they use terms of endearment and there's a lot of laughter" and "Staff go out of their way to make people happy, they spend time talking to them. We are a caring environment".

There was clear guidance for staff within care plans about how to best care for people. There were entries such as "Spend time talking to 'person's name' and enjoy a laugh and a joke". One person's care plan contained an entry in the daily notes relating to an incident which had caused the person embarrassment. The staff member had taken very caring steps to reassure the person and make them feel better. The GPs said "I've always found the care staff compassionate and caring".

People were encouraged to maintain their independence. There was clear guidance for staff relating to people's abilities and how these should be encouraged and maintained. There were entries such as "Support them to feel clean and comfortable and maintain as much independence as possible", "Support them to maintain their independence, they will wash their own teeth but need a carer to give them a wet shave and they will dress themselves but need someone to do their bottoms up". This means people were encouraged to maintain their independence whilst receiving care.

The service provided end of life care which was respectful and dignified. One GP praised the service on the way they delivered end of life care. They said "They're very good at end of life. Very attentive. Patients are always seen as individuals". The service had taken steps to ensure a person could continue to receive their care in the residential home,

Requires Improvement

Is the service caring?

according to their wishes, as opposed to moving to the nursing home. They had conducted risk assessments and had put appropriate plans in place in order to respect this person's wishes.

Is the service responsive?

Our findings

The service was responsive.

Each care plan was very person centred and focussed on people's personalities and the ways in which the service could improve their enjoyment of life as well as delivering their care needs. Care plans contained a very large amount of detail about people, their healthcare needs, their personal care needs, their moving and handling needs and behavioural needs. There was very clear information for staff about the needs people required and how staff should meet these needs.

People benefitted from activities such as visiting musicians and crafts. We saw people were encouraged to participate in activities. Where people did not want to participate, staff told us they spent time speaking with people in their room. People told us how much they enjoyed the musicians. We observed people being encouraged to take part in activities and being offered choices. Care plans showed people and their relatives had been asked for their feedback in relation to their preferences when it came to activities, music preferences and television preferences. Staff told us they took steps to ensure people did not become isolated and always tried to spend one on one time with people.

There was an effective system to manage complaints or concerns about the service. People, relatives and staff told us they felt comfortable raising concerns or complaints. Relatives told us of their experiences in complaining about an aspect of the home and this had been dealt with very quickly and efficiently. The service's complaints records showed these concerns had been dealt with according to the service's complaints policy. Complaints had been investigated and responded to appropriately. Staff told us of changes the service had implemented following concerns they had raised and they felt confident the service would respond satisfactorily to complaints.

Inadequate

Is the service well-led?

Our findings

The service was not always well led.

Our previous inspection in August 2013 found the service was not complying with Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which relates to record keeping. During this inspection we found that the issues identified were still present and had not been appropriately addressed. Records were not always appropriately maintained and kept up to date. Systems to identify these short comings were not in place or had not identified the issues, over a prolonged period. Information was not always recorded in a way that was easily accessible to staff. Some records had not been appropriately updated. A staff member said "Sometimes there are things missing on the records" and "It's hard getting staff to document". The registered manager and the deputy manager spoke to us about records and told us they were aware there were issues with the service's recording. They told us they were working towards creating a more robust process to ensure records were appropriately maintained. Although the service were aware of issues relating to their records since 2013 they had not taken timely action to rectify these.

The systems in place to ensure staff were delivering people's care according to the care plans were not adequate.

There were no systems in place to audit repositioning charts which meant the service was unable to ensure people were protected from pressure damage. There were also no systems in place to audit fluid charts or food charts. There were not appropriate systems to identify issues relating to people's topical medicines not being applied as prescribed or being ordered as required. Appropriate audits relating to people's medicines had not been completed.

People were not always being spoken to respectfully and this had not been identified by the service's monitoring systems. The service had appointed a senior member of staff to train others and monitor their performance in moving and handling, so although there were monitoring systems in place in relation to staff these had not identified the issues found during our inspection.

Although there was detailed guidance for staff in relation to caring for people, the lack of monitoring systems meant that people were not always getting the care they required. Staff were not adequately supervised which meant the management were unable to ensure people were getting the care they needed or were being treated with respect and dignity. The systems in place relating to quality assurance were inadequate and had not identified some significant concerns.

This is a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they enjoyed working at the service. They told us the management team were supportive and they felt very much part of a team. They told us the service encouraged openness and feedback. They said "If I need anything the management get it for me", "I feel comfortable to complain, we have staff meetings and we feed back during them". Staff we spoke with were very comfortable sharing their views and talked highly of the atmosphere and team work within the home. Staff surveys had been issued, completed and analysed. Key issues had been identified and were being discussed. There was a complaints and suggestion book by the entrance to each home that people were free to complete. This means the service had taken steps to gain people's feedback.

Checks had been carried out in relation to the building safety, such as fire risk assessments and water safety. Emergency plans had also been created in response to severe staff or nursing shortages for instance. This means the service had taken steps to assess and monitor the quality of the service; however they had not taken sufficient steps to ensure people were receiving safe and adequate care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not treated with dignity and respect. Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services were not protected against the risk associated with the management of medicines, the service did not ensure there were sufficient quantities of medicines to meet people's needs and the service had not taken appropriate steps to identify and mitigate risks. Regulation 12 (2) (a) (b) (f) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People who use services were not protected against the risk associated with inadequate nutrition and hydration. Regulation 14 (1) (2) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Persons employed by the service did not receive appropriate supervision and appraisal as is necessary. Regulation 18 (2) (a)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There were not adequate systems and processes in place to assess and monitor the quality of the service being delivered or to mitigate risks to the health and welfare or service users. Complete and accurate records were not maintained. Regulation 17 (1) (2) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured people who use services were protected against the risk associated with the management of medicines, the registered person did not ensure there were sufficient quantities of medicines to meet people's needs and the registered person had not taken appropriate steps to identify and mitigate risks to service users.

The enforcement action we took:
Warning Notice issued