Forest Care Limited

Rowan Lodge

Inspection report

Crown Lane
Newnham
Nr Hook
Hampshire
RG27 9AN

Tel: 01256762757
Website: www.forestcare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 3 and 8 May 2018 and was unannounced.

Rowan Lodge is a care home service with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided. Both were looked at during this inspection.

Rowan Lodge is registered to provide accommodation and support to 60 people across three floors. The home had a large garden with tables and chairs, which was regularly used by people. At the time of the inspection there were 47 people living at the home.

The service was last inspected on 25 and 30 August 2016 when it was rated overall as 'Requires improvement'. This was because although improvements had been made to staff training, people and their families were more involved in care planning, action had been taken to ensure consent to care and treatment was gained lawfully and quality assurance systems had been improved, not enough time had passed for these changes to be fully embedded into staff's practice. At this inspection, we found the provider had made the necessary improvements to achieve a rating of overall 'Good'.

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

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were systems in place to protect people from avoidable harm and abuse. Staff had received safeguarding training and were knowledgeable about actions to take if they suspected abuse. Sufficient numbers of staff were deployed to meet people's needs and keep them safe.

There were safe recruitment processes in place to make sure the provider only employed workers who were suitable to work in a care setting. Medicines were stored, recorded and administered safely.

People received care from staff who had appropriate knowledge and skills. Staff were given regular supervision and training to help develop their knowledge.

Staff were aware of the legal protections in place to protect people who lacked mental capacity to make decisions about their care and support.

People were supported to eat and drink enough to maintain a balanced diet. Snacks and drinks were

available to people at all times. People were supported to access care from relevant healthcare professionals.

Staff had caring relationships with the people they supported and knew them well. Staff encouraged people to communicate their needs and promoted their privacy, dignity and independence.

Care plans reflected care and support that people required and were written in partnership with people and their families.

The provider had processes in place for investigating and responding to complaints and concerns.

The provider had plans in place for delivering end of life care for people. Staff had undertaken end of life care training and an end of life register was used to assist staff in monitoring people if they were in need of end of life care.

Systems were in place for monitoring efficiency and quality within the service so that improvements could be made. These needed to be developed to reflect all actions taken to improve the service.

The provider worked in partnership with healthcare professionals to drive improvements in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to protect people from the risk of harm or abuse. Risks to people's safety were effectively assessed and managed.

Sufficient numbers of staff were deployed to keep people safe and meet their needs. There were safe processes in place for managing people's medicines.

People were protected from the risk of acquiring an infection.

Staff reflected on and learned from incidents.

Is the service effective?

Good

The service was effective.

Staff had the appropriate skills and knowledge to meet people's needs.

People were supported to maintain a balanced diet.

Staff worked effectively with healthcare professionals to ensure people received healthcare support.

Staff were trained in the Mental Capacity Act 2005. They sought consent from people before carrying out any care or treatment

Is the service caring?

Good

The service was caring.

Staff developed kind and compassionate relationships with the people they supported.

People were supported to express their views.

Staff treated people with dignity and respect at all times.

Is the service responsive?

Good

The service was responsive.

People received care which adapted to their changing needs.

People knew how to complain and their complaints were responded to promptly.

Plans were in place to provide end of life care to those who required it.

Is the service well-led?

Good

The service was well led.

The registered manager maintained a supportive culture and displayed strong leadership.

There were systems in place for monitoring the quality of the service.

The provider used a number of methods to involve people, relatives and staff in decisions about the service.

The provider worked effectively in partnership with healthcare professionals to meet people's needs.

Rowan Lodge

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.

The inspection took place on 3 and 8 May 2018 and was unannounced. The inspection team included two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both experts had experience of caring for older people who use services.

Before the inspection, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed records which included six people's care plans and six staff recruitment and supervision records. We also looked at records relating to the management of the service such as the Service Improvement Plan (SIP), quality assurance audits, resident meeting minutes and the staffing dependency tool as well as policies including infection control, medicines management and safeguarding.

Not everyone was able to share with us their experiences of life at the service. So we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, service manager and director of services as well as seven six care and activity staff and one registered nurse. We also spoke with thirteen people living in the home and eight family members.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe. One said, "I feel safe because there are always people around. I would have no hesitation in expressing a concern if needed." Another person said, "Yes I feel safe, they know what they're doing and how to help me."

Robust systems and processes were in place to protect people from the risk of avoidable harm or abuse. Staff had received safeguarding training as part of their induction which was refreshed every three years. Current guidance recommends that staff receive yearly safeguarding updates. We discussed this with the provider and they have assured us they will review the frequency of staff training in this area. Staff displayed thorough knowledge about the types of abuse and actions to take to protect people and had a good understanding of the provider's safeguarding and whistleblowing policies. Staff embedded safeguarding knowledge into their daily practice. One staff member told us, "We do have training we make the learning part of when we're on shift so it sticks in your brain."

The registered manager reported any allegations of harm or abuse to the Care Quality Commission (CQC) and the local authority promptly. Any concerns were thoroughly investigated by the provider.

Detailed assessments were in place to identify risks to people's health and wellbeing. People's care plans contained personalised risk assessments with specific guidance for staff on managing people's conditions. One person had a specific care plan and risk assessment around their diabetes management. This included the main symptoms of hyperglycaemia and hypoglycaemia (high and low blood sugars) and the action staff needed to take in case these occurred. There was instruction for staff to rotate people's injection sites to prevent the build-up of hard lumps that could interfere with the absorption of their insulin.

People's care plans contained specific information about their health needs. One person had a risk assessment in relation to their behaviours which could challenge staff. This identified the signs and triggers for the behaviour and interventions staff could take to de-escalate the person's anxieties. These included sensory activities and doll therapy. Another person was at risk of skin breakdown due to being nursed in bed. Their risk assessment contained specific guidance for staff on how and when to help the person change position to prevent skin damage. Records over the past week showed that staff had repositioned them according to their care plan.

Sufficient numbers of appropriately qualified staff were deployed to meet people's needs and keep them safe. The provider used a dependency tool to allocate the number of staff needed. This identified the number of care hours required by each person living in the home and the number of staff required to deliver their care. Agency staff were used to cover shortfalls in staffing. As much as possible the provider ensured that they maintained continuity by requesting the same staff.

Rotas for the four months prior to the inspection confirmed that there were enough care staff on shift to support people safely.

Robust recruitment checks were used to ensure that only staff who were suitable to work in a care setting were employed. Staff files contained evidence of two previous employer references, right to work in the UK, photographic identity and checks with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with people made vulnerable by their circumstances.

There were processes in place to ensure people's medicines were recorded, stored and administered safely. The provider used an electronic medicines administration system to ensure people received their medicines safely. This included a number of safety features. For example, the electronic recording device prevented staff from giving time sensitive medicines early. If early administration was attempted, this was prevented by the system, recorded on the electronic device and a report was generated. This was then checked by the registered manager and reviewed using the daily and weekly medicines audits. The registered manager was able to identify trends and address areas for improvement. This ensured that mistakes were prevented and that people received the correct medicines at the prescribed intervals.

People's allergies were recorded on the electronic system. If people had been prescribed creams or ointments these were recorded on their medicines administration record and body maps were used to indicate where these should be applied. Medicines were given by suitably trained, competent staff who received yearly training updates. The registered manager completed observations of staff to check their competency. The registered manager worked in partnership with the GP and pharmacy to request medicines using an electronic system. This ensured that medicines were delivered promptly and prevented the home from running out of stock.

People were protected from the risk of acquiring an infection. People told us that staff maintained high standards of cleanliness and hygiene. One person said, "Rooms are kept spotlessly clean. [They are] always nicely dressed and clean." Another person told us, "I can't fault them, yes they wear gloves and aprons [and] wash their hands." The provider had an infection control policy in place which was followed by all staff. We observed staff using the appropriate personal protective equipment when delivering care to people such as gloves and aprons. People living in the home were supported to maintain good personal hygiene. Clinical waste disposal areas were regularly checked and were clean. Clinical waste was disposed of in the appropriate bins.

The provider maintained a record of accidents and incidents and used these to reflect upon ways to improve peoples' care. The registered manager told us that incidents were reflected on during team meetings and informal conversations.

Good

Is the service effective?

Our findings

People's needs and choices were assessed by the registered manager and suitably qualified registered nurses prior to them moving to the home. With people's consent, assessments were conducted in partnership with people and their family members. Care plans included information about people's health and wellbeing needs as well as details about their life histories, working lives and hobbies. The care plans we reviewed contained specific guidance to assist staff to support people according to their needs and preferences.

The registered manager used current guidance and advice from suitably qualified healthcare professionals when planning care for people. Where people required plans for end of life care, assessments were completed using guidance from appropriate sources such as the Six Steps end of life care model in combination with advice from a clinical nurse specialist.

Staff completed an induction programme before starting work. All staff had completed their mandatory training. This was confirmed in the training matrix. The registered manager used an effective system to monitor staff training which sent staff alerts two months before their training was due to expire. This ensured that staff training needs were identified and met. Records showed and staff confirmed that they received regular supervisions and appraisals.

Five members of staff were completing National Vocational Qualifications in health and social care. One staff member was undertaking the Care Certificate, which is an agreed set of 15 standards setting out the expectations for the knowledge, skills and behaviours of those who work in health and social care. The registered manager worked with a specialist nurse to deliver dementia training to staff.

People were supported to maintain a balanced diet. Menus were displayed on the home's noticeboards and in communal areas. The registered manager told us people were given a choice of meals each day. If they requested a meal which was not on the menu, staff would provide them with an alternative. Evidence based nutrition screening tools and risk assessments were in place for people at risk of malnutrition or dehydration and dietary intake was recorded for these people.
We saw that snack tables were placed around the home so that people could help themselves.

Staff worked effectively with a number of healthcare professionals to meet people's needs. During the inspection, we observed people being assessed by an optician. The registered manager told us that the optician attended regularly to test people's eyesight. A GP also attended the home and completed a weekly doctor's round. Staff reviewed the health needs of people and referred them to the GP where appropriate. A health professional we spoke with commented on how staff communicated people's needs effectively. They said "You can rely on them." The registered manager told us that they attended regular 'link' groups in order to update their knowledge. Information from the link groups was then made available to registered nurses and carers. This ensured the registered manager supported staff to develop their understanding and skills.

The registered manager told us they worked closely with their nominated pharmacy to develop and

maintain an effective electronic medicines ordering system.

People's care plans contained hospital passports so that important information could be shared with healthcare professionals in hospitals, with the person's consent. These were completed by healthcare professionals before people were discharged from hospital.

The home was suitable for people's needs. The home consisted of a ground floor and first and second floors with lifts to access floors. There was also a large, attractive garden with tables and chairs. The registered manager told us that people enjoyed using this space in the warmer months. Corridors, doorways and rooms were wide enough to allow wheelchair access. Rooms had en-suite bathrooms and there were shared bathrooms for people. These had been decorated in a homely way with pictures on the walls. People's rooms contained personal objects and furniture and photo boxes had been placed outside people's rooms. There was a cinema area with a large screen as well as a bistro dining area. The registered manager was engaged in a project to make one of the floors more suitable for people living with dementia, however this work had not been completed. Walls were painted to help people orientate themselves and one of the corridors had been decorated to look like a street. The registered manager told us that people seemed to enjoy spending time in this area and that they were planning to extend the same improvements to other specific areas within the home.

The Mental Capacity Act 2005 (MCA) 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had been trained in the Mental Capacity Act (2005) and were observed applying its principles when caring for people. For people who lacked capacity to make certain decisions, staff were aware of the importance of giving them choice whenever possible. One staff member told us, "You can't have a certain time for meals…they eat when they want."

Staff sought consent from people before commencing their care. Where people were deprived of their liberty in their best interests, the registered manager had made the appropriate applications. The provider maintained an up to date record of the applications due to be approved. Records of best interest decisions made on behalf of people for consent to treatments and to share information with healthcare professionals were also contained in people's care plans.

Good

Is the service caring?

Our findings

People told us that they had positive, respectful relationships with the staff who cared for them. One person said, "They're helpful, kind and caring…willing to sit and chat time permitting. Lovely people." Another person told us, "Yes [they're] very kind and caring. Patient when I'm in a mood and can't remember things." Another person said, "I'm perfectly happy. They're like my family." Relatives we spoke with said their family members were treated kindly. One person said, "They always treat [relative] with respect when I'm there, ask if they can help. I think it's how they genuinely are."

Staff treated people in a compassionate and kindly manner and were very aware of their emotional needs. We observed a member of activity staff reading to someone with memory difficulties. They were discussing historical events from the person's past and encouraging them to name famous people in the book. They were exchanging smiles and laughs and the staff member clearly knew the person well and was able to support them.

Staff were adaptable to people's changing needs and preferences. Evidence in people's daily records showed that they declined personal care, but were offered and accepted it later in the day. Care plans included a 'This is me' document which helped staff identify and meet people's preferences.

People told us that they were involved in decisions about their care and that their views were listened to and acted on. One person said, "Yes- so far everything is running smoothly." Another person said, "I'm lucky enough to need little assistance but [loved one] has more needs. We make decisions together."

We observed a mealtime at the home, during which staff were attentive to the needs of people living with dementia. They communicated effectively with people; talking at eye level, giving people time to respond, and showing people plates of food available to help them choose their meal. Staff were adaptable in their approach and were not regimented about where people sat or whether they ate at a specific time. Staff recognised that the layout of the building could be confusing for some people so they supported people to orientate themselves within the home.

Staff we spoke with gave examples of how they respected and promoted people's privacy, dignity and independence. These included knocking before entering someone's room and ensuring people were covered when they were receiving personal care. People we spoke with told us that their privacy and dignity was respected. One person said, "They are pretty good. They always ask if they can help me, knock if door is closed." Staff spoke warmly about the people they cared for and how they promoted their independence. One staff member said "All our residents here are lovely. We just want to do the best we can for them." Another told us, "We try to encourage people to get up and eat their meals downstairs. It helps to keep them as active and independent as possible." As staff had a clear understanding of people's needs they were able to support them effectively.

Good

Is the service responsive?

Our findings

People's care plans were personalised and included information about people's backgrounds, communication needs, behaviour and preferred personal care routines. In one example, one person did not always recognise the need to engage in personal care tasks due to a medical condition. They required staff to prompt and support them to carry out their preferred personal care routines and present themselves in appropriate dress to their taste. The person's appearance was consistent with the preferences identified in their care plan.

The service had recently started using a computer based monitoring system to record care notes and observations regarding people's health and wellbeing. Staff used portable devices provided by the service to update people's records. This included details about medicines administration, personal care, food and fluid offered/taken and any incidents that took place. Senior staff were alerted if any planned activities such as medicines administration did not take place. This enabled them to monitor the care people received and be responsive to changes in people's health and wellbeing. Electronic care plans were updated instantly and were 'live' documents that accurately reflected people's needs at the time. This ensured staff had the latest information to enable them to provide care which met people's changing needs.

Staff were responsive to changes in people's health and wellbeing, making appropriate adjustments to care when required. In one example, a person who had recently been admitted to the home was showing signs of confusion and distress. Staff monitored their wellbeing and provided the person with ongoing 1 to 1 support to help them feel more assured, relaxed and comfortable. This demonstrated that staff were responsive to making appropriate changes to the care they provided in order to meet people's needs.

The provider ensured that people had access to information they needed in a way they could understand and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The service had complied with the Accessible Information Standard by identifying, recording and sharing the information about the individual communication needs of people with a disability or sensory impairment. People's care plans detailed strategies staff could use to promote effective communication with people, including when they were unable to vocalise their needs. This included identifying non-verbal cues people used which indicated their mood, preferences and choices. One person's care plan detailed how they would make specific facial expressions, which could indicate how they were feeling. The care plan detailed how to interact with the person in response to these non-verbal cues. This helped enable staff to communicate effectively with people to help ensure their wishes and needs were met.

There was a policy and systems in place to deal appropriately with complaints which was displayed clearly in the entrance to the home. This gave details of how people could make a complaint and to whom. We reviewed the provider's complaints log. This contained information about a recent complaint. Although there was evidence that the complaint had been resolved there were no records of how it had been

investigated such as care logs, records of meetings with staff or evidence of staff training. We raised this with the registered manager who explained that staff had received training and supervision following the incident. We advised the registered manager to record investigations, actions and lessons learned in their complaints log so that they could evidence learning and improvements following incidents.

The registered manager had arranged for staff to receive additional training in 'end of life care.' They accessed the 'Six Steps Programme'. The Skills for Care 'National end of life qualifications and six steps guidance describes the six steps programme as, 'The qualifications developed are for those working in social care and can equip workers not only to recognise end of life situations but to manage them more effectively.' A healthcare professional we spoke with told us the provider delivered a good standard of care. They said, "They are pretty good...they can use syringe drivers, they're trained. Any problems, they phone the district nurse."

People were supported by staff to make an 'end of life plan.' This detailed their choices and preferences around their care arrangements during their last days and after they had passed away. These plans include considerations about people's cultural beliefs, preferences around medical interventions and the arrangements for their body after post passing.

The registered manager told us how they worked with other stakeholders to help give people as pain free and dignified death as possible. There were examples where the service had worked with doctors, district nurses and hospices to provide a co-ordinated effort to ensure that people had access to the appropriate medicines and support to remain at the service during their last days.

Good

Is the service well-led?

Our findings

The registered manager had a vision to provide person-centred care which reflected people's needs and preferences. This approach was shared and understood by the staff team. Staff we spoke with told us there had been improvements in the home since the registered manager had taken up their post." One person told us, "Since [registered manager] came there's so much more structure, everyone knows their place, knows their job. A health professional we spoke with told us, "The home has improved a lot since [the registered manager] came." The registered manager demonstrated a personalised approach to caring for people. They said "You walk and talk like you're with your parents."

Staff we spoke with told us the registered manager was an approachable, positive role model who was responsive to the views of staff. One staff member said, "If we think something [registered manager] doing is wrong we can approach [them]…[they treat] everyone the same. [They've] put in all these things for the residents [they're] a breath of fresh air. [They're] a great manager." The registered manager spent time on the floor with staff and people and clearly knew people well as they were able to describe several people's interests and talk about their life histories.

There was a defined management structure in place which ensured that the registered manager was supported by the service manager and director of services. The registered manager was also supported by the head of care, an experienced, registered nurse who took responsibility for overseeing nursing care within the home. The management team worked collaboratively to identify and implement improvements in the service and to ensure that people received responsive nursing care.

Systems had been implemented to monitor quality within the service. Quality assurance inspections were completed by an external company. Following this a Service Improvement Plan (SIP) was generated which detailed areas for improvement identified in the inspection. Although this identified several areas for development, it did not fully reflect all of the work being undertaken by the registered manager and staff team to drive improvements. Many actions had been met but as no completion dates were included on the SIP, the timescales and targets for improvements were not clear. Although it was clear that several improvements had been made such as the transfer of paper to electronic records and adaptions to the building to make it more dementia friendly, these were not identified in the SIP. This meant that the provider had not fully evidenced all the work undertaken and had a lack of ownership of the SIP. We raised this with the registered manager who assured us that they would develop the existing SIP to include all the developments in the home as well as timescales for completion.

The registered manager completed monthly audits for areas such as medicines, care plan reviews and staff training. Results from audits were used to identify areas for improvement. For example, the medicines audit highlighted which staff members required competency assessments or retraining as the registered manager received alerts when medicines administration errors were made.

Staff were clear about their roles and responsibilities. There was registered nurse or senior carer in charge of managing a team of care staff on each floor. Communication between staff was effective. One senior staff

member told us, "If they do have worries or concerns they will come to me straight away." The team of activity coordinators and assistants ensured that a varied activities programme was available to people. On the day of inspection, people were enjoying a 'Zumba' class.

The management team communicated with staff through supervisions, team meetings and handover meetings. The registered manager held 'Flash' meetings with nursing staff to share information about people's health needs, treatments, identify safeguarding concerns and to plan of end of life care for people. Staff we spoke with felt that this was an effective approach to ensuring people's care needs were updated so that they received responsive care. One staff member told us, "[The head of care] will do the doctors round and feedback in the flash meeting. [The registered manager] covers safeguarding…we all take our diaries, if there's any training or info they give it out. We use our [patient care service device]. [The registered manager] prints out any reports and any medicines [needed]…we can make sure things are up to date."

The provider held quarterly residents and relatives meetings to gather people's feedback on the service in order to drive improvements. In a recent meeting it was identified that the sink in the salon needed repair. This was repaired, and documented in the following meeting.

The provider engaged with people's relatives and invited them into the home at any time. The registered manager maintained an open dialogue with relatives and invited them to attend events in the home such as a retro drive in cinema night. Members of the local community provided specially adapted cars for people to sit in to recreate the drive in experience. The registered manager had also engaged with a relative of a person who had passed away to organise a classic car day for people.

The registered manager promoted a culture of learning and reflection in the home. There was an accident and incidents log which was used to analyse trends such as occurrences of falls. Following a recent falls analysis the registered manager had deployed additional staff in a communal area. Records showed that this had significantly reduced the number of falls.

The registered manager had made improvements to the way prescriptions were ordered. This was confirmed by a healthcare professional we spoke with. They told us, "Electronic prescriptions go direct to pharmacy. It helped to minimise constant requests. It's more efficient, it's improved a lot." The registered manager liaised with their designated pharmacy and GP surgery to ensure that medicines were ordered in a timely way. This ensured that people received the correct medicines at the correct times.

The provider worked effectively in partnership with a range of professionals. The registered manager worked with a nurse specialist to develop staff training in dementia care and end of life care. The provider was taking part in a project with the local community health trust to develop non-medicinal care for people living with dementia. The registered manager collaborated with a healthcare professional to develop staff knowledge and understanding in this area.