Clarendon Care Group Limited

# Foresters Nursing Home

## Inspection report

Walton Pool
Clent
Stourbridge
West Midlands
DY9 9RP

Tel: 01562883068

Date of inspection visit:
12 February 2016

Date of publication:
25 April 2016

## Ratings

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

# Summary of findings

## Overall summary

The inspection took place on the 12 February 2016 and was unannounced.

Foresters Nursing Home is located in Clent. The home is registered to provide-personal care and accommodation for up to 30 older people. On the day of our inspection there were 23 people living at the home.

Since our last inspection the registered manager had left and a new manager appointed. There was a manager in post who was in the process of applying to CQC to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

Although people had care plans in place, we saw some of the information was did not reflect people's current support requirements. People and their relatives had not had input into their care plans. Therefore staff could not be sure whether they were caring and supported people in the way they preferred.

People were supported to receive their medicines in a timely manner and medicines were stored securely and at the correct temperature.

People were supported to have drinks and snacks throughout the day, People enjoyed the food they received and were positive about the choice the given to them.

People told us they didn't have enough activities to do. There was little evidence to support people maintain interests and activities of their choice. People who were confined to their rooms were at risk of social isolation.

People's care files and personal information were not always kept confidential and secure.

People were protected from harm, the manager and care staff knew how to recognise abuse and what action to take if they suspected it. Risks assessments and risk management plans were in place to but not all staff knew where to find the information.

People were provided with care that protected their freedom and promoted their rights. Staff asked people for their permission before care was provided and gave people choices about their support. Where people had not got mental capacity the provider had engaged relatives and best interest meetings to represent people's wishes.

People knew how to make a complaint or raise a concern and felt happy to discuss it with the manager.

The provider was in the process of a lot of changes due to the change in manager and the systems in place to monitor and improve the quality of the service were not yet embedded. The manager and provider had identified many improvements that were needed and had plans in place to improve the quality of the service.

The manager promoted a transparent and open culture. They recognised the areas for improvement required at the home and had a home development action plan in place to address the issues.

## 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**

This service was not consistently safe

People's access to staff was limited because there were not enough staff to respond to people's needs.

People's medicines were appropriately stored and administered.

### Is the service effective?

**Good**

This service was  effective

People told us they enjoyed the food provided.

Where people needed their food and fluid intake monitoring, this was not always completed.

The provider followed the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

### Is the service caring?

**Requires Improvement**

This service was not always caring.

People's right to confidentiality was not always respected; records were not always stored securely

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People had individual care plans but there was a lack of people's involvement in the production and reviewing of them. Therefore staff could not be assured they were supporting people in line with their current preferences.

People had limited opportunity to follow their interests and do activities

### Is the service responsive?

**Requires Improvement**

This service is not always responsive

Some people were in their rooms for large periods of the day or stayed in their room all the time and were at risk of isolation.

People were supported to maintain relationships with their families.

## Is the service well-led?

Good

This service is well -led

People felt that the new manager had made positive improvements.

The manager was clear about the responsibilities of their role.

Systems were in place to monitor the quality of the service, through regular audits and performance monitoring. Although the provider was in the process of a lot of changes due to the change in manager and the systems in place to monitor and improve the quality of the service were not yet embedded.

# Foresters Nursing Home

**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.

The inspection took place on 12 February 2016 and was unannounced. The inspection team consisted of two inspectors, one specialist advisor, whose expertise was nursing care for older people. There was also an expert 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 services.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. We contacted the local authority and Healthwatch to see if they had any information to share about the service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 spoke with 11 people who lived at the home and four relatives. We observed how staff supported people throughout the day. As part of our observations 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 manager, deputy manager, the regional manager, four staff, the cook and housekeeper. We looked at four care files and three staff files. We also looked at the complaints file, staff meeting minutes and the quality assurance audit files.

Requires Improvement

# Is the service safe?

## Our findings

Although people told us they felt safe we observed a time period of 25 minutes when staff were not available to people in the communal lounge on the morning of our inspection. Some people using the lounge at this time, required support to mobilise and needed assistance with personal care. During that time we saw people required help but it was not available, they had to wait until staff returned. A member of staff explained there was normally one staff allocated to the lounge to assist people but they were working elsewhere in the building on the day our inspection.

Current staffing arrangements did not provide a person-centred approach to meeting people's needs at all times. One person told us "Most of the time there is enough staff except for the weekends when they use agency staff. One staff member told us "There is a high-turnover of staff and a heavy reliance upon agency staff". Another member of staff told us, "Staffing levels are generally adequate but mornings were very tight time wise." The manager assessed staffing requirements based on people's dependency levels and reviewed them accordingly. However the manager and deputy manager told us they tried to cover the shifts with permanent staff but due to difficulties with recruitment they had to use agency staff. We spoke to the manager about the difficulties in recruiting staff; they felt the rural location of the home and lack of public transport made it difficult for staff to access the home. It had been difficult to recruit registered nursing staff and they currently had one vacancy.

We looked at three staff files. The manager had drawn up an action plan to demonstrate they were aware of the problems of previous recruitment processes and were addressing them in order to keep people safe. We did see evidence of people employed had Disclosure and Barring Service Checks to ensure suitable staff were employed.

People were supported by staff that knew how to recognise when people were at risk of harm and what action they would need to take to keep people safe and to report concerns. This was because the provider had trained staff to identify the possibility of abuse and prevent abuse from happening. The provider's safeguarding policy set out the responsibility of staff to report abuse and explained the procedures they needed to follow. Staff understood their responsibilities and what they needed to do to raise their concerns with the right person if they suspected or witnessed ill treatment or poor practice. The provider had submitted local authority referrals where necessary and this demonstrated their knowledge of safeguarding process.

We looked at how the provider managed people's skin healthcare. We saw one person had a pressure sore which was not dressed following their shower until three o'clock in the afternoon When we queried this with a staff member who was a qualified nurse, we were told it had been left to dry out. However, following further discussion with this person we could not be clear whether this had the potential to lead to further infection. We asked the manager for information about the wound to see how the healing had progressed, however we were told there were some information was not available. The manager told us they usually took photographs and measurements of pressure sores but admitted on this occasion it hadn't been done. We were told that another photograph and measurement of the wound would be taken. We saw from the

care records the nurse had liaised with the specialist tissue viability nurse, (who advises providers on sore skin and wounds) on the best care for the person's wound. The manager told us once the photograph of the wound had been taken they would email it over to the tissue viability nurse for further advice.

We noted that one person's pressure care mattress was not working properly as the connection had become dislodged. We checked other people's pressure mattresses and found they were not set up correctly according to people's weight. We brought this to the attention of the manager and the nurse on site, they went to each person affected and adjusted their bed to the correct pressure setting.

For other elements of care risk management processes had been put in place. For example we saw that people at risk of falls had risk assessments in place and these were regularly reviewed or updated when necessary.

People we spoke with told us they had their medicines on time and were happy with staff supporting them to take their medicines. One person told us, "Medication is brought regularly and they make sure that you take it, they never miss." □

We saw staff support people to take their medicines; they explained what they were taking and sought consent before they administered them. Staff were trained and assessed to be able to administer medicines. Staff were aware of what to look for as possible side effects of the medicines people were prescribed. We saw suitable storage of medicines and there were suitable disposal arrangements for medicines in place.

Good

# Is the service effective?

## Our findings

The people we spoke with were positive about the meals they were provided with, both in terms of choice and quality. One resident told us, "the food here is quite excellent, and you choose what you want".

We saw that there was a choice of meals offered and residents ate most of their meals and were offered drinks. People who required assistance with eating received this support throughout lunchtime and the meal was not rushed.

Staff were aware of people who had specific dietary requirements as this was recorded on the daily handover sheets and a board in the kitchen. We saw there were sugar-free options for desserts for people with diabetes, as well as the option of fresh fruit.

Staff told us they felt they received sufficient levels of training in order for them to do their jobs. They told us the training included end of life care, medication administration and manual handling. One staff member told us that the manager had arranged forthcoming training in 'How to Recognise Deterioration in Health'. One staff member had completed her NVQ 3, and another was in the process of completing her NVQ2.

Staff told us they felt supported in their role by the manager, and that in addition to supervisions, they could approach her at any time for support. Existing staff told us that their induction had consisted of shadowing one shift and then they "learnt as they went along". However, we saw that a new induction programme had been introduced which included a week of shadowing in conjunction with mandatory training.

Staff were able to explain to us how they assess and meet people's needs. For example, one staff member told us she identified a person needed a profiling bed. She raised this with the manager, and the bed was obtained that same day. Another staff member told us that [person's name] had been assessed before moving to the service and had been assessed as being unable to walk. However, staff observed the person being able to walk, and so they obtained a walking frame for them. Due to some people's physical needs, regular monitoring was required to maintain their health. We saw that people's vital signs were checked monthly on some people but on a few instances we saw a person's body temperature had dropped to a low temperature. One person had a blood pressure with a very low reading, but it was unclear from the records if medical advice was sought. When we asked the staff what they would do if they thought someone's condition had changed on staff told us "I'd report it to the manager or deputy manager". They felt assured they would take action. Although from the records we saw it was not evident this was always the case, when people's health monitoring records should have raised concern, it had not be actioned by staff.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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

was in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)..

We checked whether the service was working within the principles of the MCA and whether any authorisations or conditions to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the MCA and DoLS and had submitted the appropriate applications to the 'supervisory body' (the local authority with responsibility for the person). Most of the people living in Foresters Nursing Home had a DoLS application in the process of being considered by the local authority and 14 applications had been approved. Staff had received training in the MCA and the associated DoLS and they were able to tell us about how this legislation affected people they supported.

We saw that the care records we looked at all had capacity, best interests and DoLS assessments completed and recorded. We saw that consent forms had been obtained for people and were within their care records and we observed peoples consent being requested for various activities such as assisting people to take medication.

We saw there were signed DNACPR (do not attempt cardiac pulmonary resuscitation) which had been completed appropriately and where kept in people's care files.

We saw that residents assessed health needs were being met. One person told us, "I have a catheter fitted, it is changed and cleaned regularly, I have no problems". We saw care plans in place for people with diabetes and that blood sugars were tested and monitored weekly. The care plans described signs and symptoms of both high and low blood sugars to give staff guidance, and staff we spoke with were able to tell us where they would look for this information. Where people received nutritional intake through a specialist tube, clear feeding and fluid regimes as set by the hospital were adhered to by staff.

Where health needs had changed for people, we saw that reviews had been arranged with GPs and appropriate action taken. For example, we saw that another person with diabetes was being monitored. People were supported to maintain their health and received referrals from external healthcare agencies as appropriate. For example, we saw appropriate referrals to health care specialists and that the opticians and chiropodist visited the home regularly.

Requires Improvement

# Is the service caring?

## Our findings

We found that staff did not always respect people's right to confidentiality in relation to their personal information. We saw one person's personal care plan was left in the dining room, so was available for everyone to see. In the home's hairdressing room (which was used by many people) there were files containing personal information in unlocked cupboards and some paperwork left on the floor.

When asked people if they had been involved with their care planning some people told us they were aware they had a care plan but were not aware of the contents or been involved with the reviewing of them. The manager was aware of this and told us they intended to make improvements, so care plans reflected people's preferences of how they would like to be supported.

People told us they felt staff cared about them. One person told us, "Staff couldn't be better; they are here when you need them and they really care about you". Another person told us "There is often not enough staff and they are not all are very caring". However relatives told us they had some concerns over the standard of care provided. One relative told us, "[person's name] had swollen hands and although we mentioned it, still no one noticed it". Another relative said "[person's name] had dried faeces on his hands when I came to visit. I told staff before they took him to the toilet but they brought him back from the toilet and it was still on his hands".

We observed some positive interactions between staff and the people they cared for. Staff were friendly and polite. However many of these interactions were task led and we saw few examples of staff having the time to sit and talk to people. People told us they were happy with the way care was delivered by staff. One person told us, "They speak to me and treat me with respect whilst administering care". Another person said, "The staff closed the curtains and door when administering personal care. They treat me with respect."

The staff we spoke with had an understanding of people's likes and dislikes and personal preferences, although we saw limited examples of staff engaging people in conversation about their interests. Staff made friendly comments as they passed through each area of the home. They took the time to say hello to people but this was rarely followed up with any meaningful and engaging conversation. The staff team appeared rushed and busy throughout the inspection.

During the lunchtime we saw how staff responded to people in a timely manner if they showed signs of discomfort or distress. We observed a person tell a member of staff they felt in pain and had become upset. The staff member showed warmth and kindness and bent down to the person's level, listened to them carefully to reassure them and told them they would fetch some pain relief for them. The medicines were administered and the person responded positively to this.

People were encouraged to stay in contact with their families and relatives we spoke with told us they were welcome to visit at any time.

Requires Improvement

# Is the service responsive?

## Our findings

On one person's bedroom wall we saw part of a person's care plan detailing how they wanted to be supported. The information provided outlined the person's preferences and preferred daily routines. A staff member told us "The information is about two years out of date." As the provider relied on different agency staff they required current information and in order to support people the way they preferred and be responsive to the person's needs.

When we asked people if they thought staff were responsive to their needs, people told us, "The staff are very busy; they have no time to talk to you." Another person told us, "I get bored, there are no regular activities." One person commented they thought night staff were not responsive to their requirements they said, "At night when you press your buzzer the staff can take quite a while." During our inspection we noted that call buzzers were answered promptly. During the morning of the inspection we observed staff were not able to spend any other time with people than the time needed to complete the task they were required to perform. For the first two hours of the inspection we saw people sitting in the one of the communal lounges with no stimulation or activities. It was not until 11am when the local church personnel came to offer a church service, when activities commenced. "The church visits every week for those who want to attend and they come to my room" a person told us.

Several people spent their time in bed with little or no activities. We spoke with one person who told us "Since coming to the home two months ago, they had not been offered any opportunities to follow their individual interests or hobbies". One person said I enjoy knitting and some men played dominoes". Another person told us "I miss being taken to the library. They used to take me, but not anymore." When we spoke to the manager about activities she acknowledged this was an area that needed improving but told us due to current staffing levels it was difficult to provide the level of service she wanted to.

We asked people if they knew how to or had raised a complaint or concern about the service. People told us they did and felt the manager would listen and respond to any complaints they made. For example, One person told us, "I had one agency staff who treated me with no compassion. I complained and was told that she would not be used again, she has never been back". Another person responded "I would speak to my social worker or a member of staff if I had a concern".
A relative told us, "I would feel comfortable raising a complaint."

The manager was able to show us the process for investigating people's concerns and complaints. We saw records of complaints looked at showed that they were investigated and responded to appropriately. The provider's complaint's policy was available for people to read should they wish to.

The manager had identified the need to give people and their relatives opportunities to give their views and opinions about life at the home. She told us in the near future she wanted to send out surveys to people and their relatives, and would add this information to the home improvement plan. She told us she would like to arrange resident meetings so people had more of a say of how the home was run.

Good

# Is the service well-led?

## Our findings

Since our last inspection to the home the registered manager had left and a new manager appointed. The manager had only been in post a few months and was currently applying to the Care Quality Commission (CQC) to become the registered manager. There was a deputy manager in post who was qualified as a general and mental health nurse and took the clinical responsibility lead to support the manager. On the day of the inspection the operations manager was also present for part of the day to provide support. We found there to be a clear leadership structure that staff understood.

At this inspection we saw some staff practices were not always effective and responsive to the individual needs of people who lived at the home. Therefore we looked at the arrangements the provider had in place to drive through improvements in staff practices so that people consistently received effective and responsive care. The manager had a clear vision of how she wanted to improve the home. She was taking the lead as dignity champion and we saw a display in the hallway to remind staff how she expected people to be treated and the values she wanted to instil into the home.

People who lived at the home and their relatives knew who the manager was and they felt comfortable to approach them at any time. One person told us "I like the new manager she is easy to talk to". A relative described how there was new management and "It's got better of late". They said the manager was approachable and they felt could speak to the manager if they had any concerns."

The manager told us that they were available to people should they wish to raise anything with them. We saw this was the case on the day of our inspection as they were visible around the home speaking with people and supporting staff in their work. One person told us, "The manager comes around often and asks if I had anything to tell her". We could see from people's expressions they were pleased to see her around the home, as she took time to chat to people and left them with a smile on their face.

All the staff we spoke with told us they thought they now had a, "good manager" and how staff morale was starting to improve. One staff member told us "Morale was very low before she started. She gets things done. For example "She has made herself the dignity champion to ensure people's rights and dignity in care is represented." Another member of staff told us, "It's a joy to work here now (under the new manager)."

Staff told us system of staff supervisions and appraisals had been introduced by the manager to give staff opportunity to reflect and improve their practice and identify training requirements. As a result they felt more supported in their role.

The manager showed us the way she recorded and monitored the quality of the service. For example we saw environmental audits and as a result she had re organised one of the old lounges and turned it into a pleasant dining room for people. She'd bought table cloths and napkins to enhance people's dining experience. The manager told us the provider made quarterly checks to the home and she regularly emailed them to up-date them on the progress she was making in the home improvements.

The manager took an open and responsive approach to the issues we identified at this inspection. She was honest and transparent about the service's shortfalls and how she was going to address them. She showed us she had devised a home improvement plan and was gradually working her way through it. They told us the home improvement plan was being monitored by the provider at their quarterly visits.