

Aspen Village Limited

# Forest Care Village Elstree and Borehamwood

## Inspection report

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Date of inspection visit:  
26 June 2018

Date of publication:  
10 September 2018

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

We carried out an unannounced inspection at Forest Care Village on 26 June 2018. At the last inspection on 05 December 2017, we asked the provider to make immediate improvements in some areas of the care and support people received. These areas were around risk management for people, safeguarding systems and processes, nutrition, consent to care, personalised care, dignity and governance systems. This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Following our inspection on 05 December 2017 we were informed by the local authority that Environmental Health officers had served a Hygiene Emergency Prohibition Notice on Forest Care Village due to an infestation of cockroaches. At this inspection we found that this notice had been lifted and the cockroach infestation had been eradicated.

Forest Care Village is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Forest Care Village is registered to provide personal and nursing care for up to 178 people aged 18 and over with a range of complex health and care needs. At the time of our inspection 120 people were using the service.

Forest Care Village spreads across three floors and accommodates people in separate units, each of which have separate adapted facilities. Three of the units specialise in providing care to people living with dementia whereas in the remaining four units people have nursing needs.

There was a manager in post who had registered with the Care Quality Commission (CQC). 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 and associated Regulations about how the service is run.

At this inspection we found that significant improvements were made and although some areas were still developing and improving, however, people received personalised care and support which was safe and protected them from the risk of harm.

Following the inspection on 05 December 2017 we shared our findings with the Local Authority and Clinical Commissioning Group (CCG). The different funding authorities and local commissioning group worked closely with the provider and the registered manager providing support to empower Forest Care Village staff and to monitor improvements as part of their quality improvement process. There were regular service

improvement meetings where different health and social care professionals gave feedback following their visits and assessments carried out at the home to the provider and register manager. A manual handling specialist had observed staff's practices and provided training. The CCG had allocated two nurses two days a week to observe and empower staff employed by the home to develop their skills further in recognising people's changing health needs. At the time of this inspection the support from the different external professionals was recently withdrawn except for PEG specialist nurses who were training and assessing staff's competencies in the management of percutaneous endoscopic gastrostomy (PEG)'s. PEG is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

The provider reviewed their governance systems and developed this further to ensure that this was effective in identifying areas in need of improvement without the permanent support from the local authority. The provider has transitioned to electronic care planning which meant that staff could access people's records from their hand-held devices and they updated the records when they delivered support to people.

People told us that they felt safe living in the home. Staff demonstrated they had the knowledge to identify potential abuse and also the process for reporting concerns. We saw notices and information displayed throughout the service informing people, staff and visitors how to report concerns and relevant contact numbers for external safeguarding authorities. Referrals to local safeguarding authorities and CQC were done in a timely manner.

There were adequate staff on duty to support people in a timely way. Call bells were responded to within a couple of minutes and people confirmed staff responded when they requested help. We reviewed rotas and saw that adequate staff were deployed to assist people safely.

People's individual risks were assessed and where risks were identified, measures were put in place to help reduce and mitigate those risks. Staff demonstrated a good knowledge about people and could tell us how they mitigated risks to people's well-being.

People who lived with specific health conditions had care plans in place to address this area of their needs and staff had guidance on how to maximise people's health. People's end of life care needs were assessed and plans were in place to evidence that people's wishes, likes and dislikes were considered when staff created care plans. Staff could tell us what people liked and how they wished to be cared for.

Infection control measures were in place. Staff were observed to use personal protective equipment, including the use of gloves and aprons while supporting people with personal care. People's medicines were managed safely in most cases. Medicines were stored safely and administered by trained staff.

Staff felt supported by the registered manager and unit managers and were encouraged to have their say about any concerns they had in how the service operated. Staff attended regular meetings and discussed issues that were important to them. They also had regular supervisions where their performance and development were reviewed. Staff told us they received training and support to carry out their roles effectively. Recruitment processes were robust and ensured that the staff employed were suitable to work in this type of care settings.

Electronic care plans were well developed, personalised and regularly reviewed. However not all the features this care planning system offered were developed to full capacity at the time of the inspection. Not every person we spoke with were aware of their care plans or the content of it, however they told us they had or were waiting for a review of their care needs.

People were asked for their consent to the day to day care and support they received from staff. We observed staff assisting people and communicating with them and asking for their involvement in the task. People told us and we observed that staff protected their dignity and privacy.

The principles of the Mental Capacity Act 2005 (MCA) were followed by staff and where Deprivation of Liberty Safeguards (DoLS) authorisations were in place with conditions listed on the restrictions to people`s freedom plans were in place to meet these and keep people safe.

People were positive about the care and support they received and told us staff were kind and caring. People were supported to engage in a range of arts, crafts, and hobbies that were of interest to them. There were singalong musical events, sporting events and outside entertainers visited the home. People were also supported to attend community events. People who were less able to engage in social activities had an identified need for staff to spend meaningful moments with them outside the care delivery, however we saw that some of these moments were not completed. This area of the service was still improving to ensure that people in their bedrooms were not at risk of isolation.

People told us they liked the food provided to them and they had enough choices. People`s dietary needs were met and we found that staff referred people to specialist support in case they were at risk of malnutrition.

After the previous inspection there was extensive support provided by the Local Authority, CCG and other partner agencies involving deployment of their own qualified staff to help the provider identify where they needed improvements and agreed actions were put in place to improve the quality and safety of the care provided to people. This support was recently withdrawn and the registered manager and the provider were yet to prove that the service could sustain the improvements achieved.

Systems had been developed to identify shortfalls and address these areas as needed. Communication through the management team had been improved. There were monthly clinical and quality meetings to discuss all areas of the service, internal audits completed and any incidents that had occurred. This enabled the management team to review previous and ongoing action plans to help ensure they were effective. Lessons were learned following incidents.

The registered manager effectively monitored the quality of the care provided to people and they were regularly walking the floors helping, coaching and mentoring staff. Regular surveys carried out evidenced that people were feeling positive about the changes in the home. There were regular relatives and residents meetings organised and a `you said, we did` poster to evidence when people requests were fulfilled, however there were some people who told us that they were disappointed that not all the issues they brought up in meetings were actioned.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People were protected from the risk of harm by staff who had a good knowledge about safeguarding procedures.

Staff were aware of risks to people`s well-being and health and how to effectively mitigate these.

There were sufficient staff deployed to meet people`s needs in a timely way.

Incidents identified and reported to managers were analysed, escalated and reported to external safeguarding authorities.

People`s specific health conditions were assessed and guidance was in place for staff to know how to maximise their health.

People were protected from the risk of infections by staff who followed infection control measures and used personal protective clothing when needed.

People received their medicines safely in most cases.

**Good** ●

### Is the service effective?

The service was not always effective.

Staff received training to develop their skills, however there was still some staff members who were developing the skills needed to look after people`s health needs.

Partner agencies were involved in supporting and developing staff to be competent in management of PEG`s.

Staff asked for people's consent before providing care and support.

The principles of MCA and DoLS were known to staff and where DoLS authorisations were in place with conditions attached these were met.

**Requires Improvement** ●

People`s dietary needs were well known to staff and these were met. People told us they enjoyed the food and they had plenty of choices.

People were supported to access health care professionals as needed to help ensure that their health and well-being was maintained.

### **Is the service caring?**

**Good** ●

The service was caring.

People received care and support from staff in a kind way.

People`s dignity was maintained.

Staff had good knowledge about people`s likes, dislikes and preferences.

Some people told us that they had been involved in their care planning and in review meetings to discuss their care needs.

Confidentiality was maintained.

### **Is the service responsive?**

**Requires Improvement** ●

The service was responsive.

People received personalised care. Care plans were reflective of people`s likes and dislikes and staff were knowledgeable about these. However, some areas of the care plans were still being developed in line with best practice.

People`s care plans were detailed around people`s needs to give staff sufficient guidance to meet their needs effectively.

Opportunities were provided to help people pursue social interests and take part in meaningful activities relevant to their needs. An external consultant had been contracted by the provider to help develop this area of the service.

People had plans in place for staff to know their wishes and preferences about the care they should receive nearing the end of their life.

People told us they could raise their issues with the unit managers; however they did not know who the registered manager was.

## Is the service well-led?

The service was not always well - led.

There were quality assurance systems and processes implemented by the provider and the registered manager which were effective, however the improvements achieved had to be proven sustainable.

The electronic care planning system was still being developed to full capacity. People`s care plans were mainly up to date and staff were positive about these.

Feedback from people, relatives and staff about the management in the home was more positive, however some people and relatives were not happy with how responsive the management team was to their issues. We saw evidence of good practice from the management team in creating opportunities for people to raise their concerns and these were actioned.

**Requires Improvement** 

# Forest Care Village Elstree and Borehamwood

## **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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 26 June 2018 to assess if the provider made the improvements they told us they were going to make following the inspection we carried out on 05 December 2017.

This inspection was carried out by four Inspectors and 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 service. The inspection was unannounced.

Before the inspection we reviewed information, we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with ten people who used the service, five relatives, 12 care staff members, two unit managers, three nurses, the chef, a visiting professional and a consultant contracted by the provider to improve the quality of the social activities and engagement offered to people. We also talked to the registered manager, the nominated individual and two other members of the provider's operation team. We looked at care plans relating to eight people and other documents relating to the management of the service including six staff files, medicine administration records and audits.

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 communicate with us.

## Is the service safe?

### Our findings

People told us they felt safe at Forest Care Village. One person told us, "I feel very much safe, I finally have my electric chair, so that makes me very movable and safe to go around house." Another person said, "I feel safe on this floor because there are carers I know and they know me. And they are very helpful." A third person said, "I feel safe here. I can have my own space in my bedroom. I feel safe because there are always staff around. I feel safer here than where I lived before."

When we inspected previously we found that people were not always protected from the risk of harm and safeguarding incidents were not always reported and investigated by external safeguarding authorities so protection plans could be put in place for people. At this inspection we found that staff reported incidents and management submitted reports to external safeguarding authorities as well as CQC.

Staff demonstrated they had the knowledge to identify potential abuse and gave us examples of how they identified abuse and also the process for reporting concerns. There was information and guidance displayed about how to recognise the signs of potential abuse and report concerns, together with relevant contact numbers. Information was also made available in an 'easy read' format that used appropriate words and pictures to help support people with their understanding. One staff member told us if they had any concerns, they would, "First I would report to my line manager." Staff we spoke with could describe types of abuse and things that would concern them. For example, changes to people's behaviour. Staff were aware of how to escalate concerns and report to outside professionals such as the local authority or the CQC.

Previously people and staff told us that there was not enough staff to meet people's needs in a timely way. We found that staff were not deployed effectively and people had not received the care and support when they needed. At this inspection we found that improvements were made in this area.

People's needs were met in a timely way. One person told us, "The staff who are looking after me are brilliant but no, I don't see much difference between night staff, they do come fairly quickly and they are kind." We saw that call bells were answered promptly and any verbal requests for support were responded to. This included while a nurse was speaking with us, they heard a person calling and so left us to support them. This showed that responding to people's needs was the priority. We reviewed the dependency log and saw that each person had a breakdown of how many minutes or hours of support they needed for morning care, afternoon, evening and night support, for their continence needs and for eating and drinking. This enabled the provider to ascertain how many care and nursing hours per day were needed on each unit.

Staff felt there was enough staff to meet people's needs. One staff member said, "Yes there are enough staff and with the new electronic system we have more time to chat to the residents." Another staff member said, "We have more time to spend with people." They also told us, "We have a good team; the seniors communicate with the other units and the unit manager supports us and will give us help if needed." A third staff member said, "We are not working short, all the time we work safe."

People were supported by staff who were recruited safely. They ensured all required documentation was received before a member of staff commenced employment. This included written references and criminal record checks.

When we inspected the service on 05 December 2017 we found that risks to people`s well-being were not sufficiently mitigated by staff to keep people safe. At this inspection we found that significant improvements were made and people were safe.

When we arrived at the service we walked round the whole building checking on people. We saw that people had access to call bells, drinks and bedrails or crash mats were in place where needed. We saw that staff worked safely. This included supporting people with clinical care such as PEGs and appropriate pressure care management. Care plans included risk assessments that detailed how staff should support people with their assessed needs. We saw that care records confirmed care had been delivered in accordance with the assessments and we tested staff knowledge in regard to these areas. This included the amount of fluid used to flush a PEG and the nurse we spoke with was aware of the increase in fluid due to the hot weather. We reviewed repositioning charts and saw that people were repositioned in accordance with their plans to help reduce the risk of developing pressure ulcers and we saw that people were appropriately positioned when eating or receiving their PEG to help reduce the risk of choking or aspiration.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. This included in areas such as medicines, mobility, health and welfare. This meant that staff could provide care and support safely. For example, one person who had begun to have falls was assessed by the GP and had their medicines reviewed. The medicines were reduced and eventually stopped and the unit manager confirmed this had made a huge difference and their falls reduced.

At the previous inspection we observed that a person at risk of choking was not supported safely to eat and drink. At this inspection we observed the same person and they were upright when eating. The person was visually impaired and required staff`s support when having a drink and their meals. We found that the way staff supported the person was safe and the staff member communicated each time they were going to place food or drink in the persons mouth. The staff member was not rushed and reassured the person to take their time.

We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight.

There were regular checks of fire safety equipment and fire drills were completed. Staff knew how to respond in the event of a fire. However, we noted that there was not a log of staff who had attended a fire drill and the provider needed to ensure that all staff had attended at least one fire drill in 12 months. In December 2017 the fire risk assessment evidenced that the provider was only 55% compliant with the areas checked, however there was a reinspection of the premises on 09 July 2018 and the provider has sent us a copy. This evidenced that they made the recommended improvements and achieved 96% compliance. The provider ensured that other checks, such as electrical or health and safety assessments, were also completed to help maintain people's safety.

We reviewed the oxygen storage. Cylinders not in use were in a locked cage in the grounds. We had confirmation following the inspection that the British Oxygen Company (BOC) has been contacted, visited and assessed and they were satisfied that the oxygen storage was safe.

People's medicines were managed safely in most cases. Medicines were stored safely and administered by trained staff. Staff received regular competency assessments. We found that there were weekly counts in place and these helped identify any discrepancies. We checked a random sample of boxed medicines and those in the pharmacy blister packs and found that most stocks were accurate with the records. However

out of the 16 boxes we counted, one person's medicines did not contain the correct quantities according to records and some of their morning medicines for that day had not been administered. We noted that where audits were completed of medicines, it was not always clear what action they took in response to discrepancies. The registered manager told us that they were discussed at their clinical and quality meetings and staff received additional training and supervision. We suggested that it would be beneficial to record these actions more clearly. We noted that where a person was assessed as needing to have their medicines covertly, the best interest process had been followed and the GP, along with the pharmacist had been involved in the decision making.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. We saw that staff used gloves and aprons appropriately and the home was clean and fresh on the day of our inspection.

Lessons learned were shared at team meetings, supervisions or as needed. We noted that any issues discussed remedial actions were put in place.

## Is the service effective?

### Our findings

People told us they felt staff were supporting them well. One person told us, "I am a resident for over a year and while I didn't have much choice about where I will be sent after hospital, I was pleased that I am here. I was very poorly first 6 months, but gradually I feel much better now." A relative told us, "[Person] needs somebody for personal care, dressing up, even reminding to eat. Some staff are very good, polite, they take time and go with [person`s] pace, when I am with them visiting I only see a fraction and it`s all good."

Relatives told us that although staff was skilled and knowledgeable about people`s basic needs and were able to deliver care effectively, specialist training about brain injury was an area which relatives would have liked staff looking after people with this need to have. One relative said, "Staff are trained to deliver good care, but basically, I don't think they have much training about brain injuries. They can certainly improve that."

Staff completed an induction programme, during which they received training relevant to their roles, and had their competencies observed and assessed in the work place. Staff received the provider's mandatory training and regular updates in a range of subjects designed to help them perform their roles effectively. This included areas such as moving and handling, food safety, medicines and infection control. Staff confirmed they had completed inductions. One staff member said about their training, "We are fully trained, two weeks ago I completed my medication training, I am also doing my dignity and safeguarding training." A senior staff member commented, "We have our own trainer who provides the training. We also have on line training and external training. The training has a competency check afterward. I look at the staff daily to make sure they are doing the job properly."

At the previous inspection staff told us they were not supported by managers. At this inspection staff told us felt supported by the registered manager and unit manager and were encouraged to have their say about any concerns they had in how the service operated. Staff attended regular meetings and discussed issues that were important to them. They also had regular supervisions where their performance and development were reviewed. A staff member commented, "I am supported, if I have a problem or don't know something they [managers and seniors] will help me. The communication is good we have a good team." Another staff member commented, "I have supervisions and appraisals. We also have group supervisions and staff meetings every month." Staff said that since the previous inspection management were more visible and supportive. One staff member said, "They are always around now, helping us on the floor if we need it, giving guidance." We saw that staff received regular one to one and group supervision and as part of those supervisions they covered key areas, such as safeguarding, training and development.

Some staff received training and become champions in key areas such as falls, care planning and nutrition, to enable them to support staff to provide effective care. However, we noted that these roles were not fully utilised yet by the management in the home. We discussed this with the registered manager who told us that they were reviewing the champions roles and will set out clear responsibilities when all the champions in the areas they identified needed will be trained. Their role would comprise in guiding and mentoring staff to follow best practice in their areas of expertise.

Until recently the management team and the provider had extensive support from the local authority and CCG to coach and mentor staff and build up their skills and competencies so they met people`s needs effectively. We found that support from specialist PEG nurses had been kept in place as not all the staff were deemed competent in managing people`s PEGs. This meant that we could not fully assess the sustainability of the improvements as this had been driven by the provider as well as partner agencies.

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 (DoLS).

Previously we found that although staff had received training not all the staff we spoke with had clear knowledge in relation to MCA and DoLS and staff did not offer choice to people or ask for people`s consent and explain what was happening when providing care.

At this inspection we found that people were asked to consent to their care. Staff understood the importance of ensuring people gave their consent to the care and support they received. One staff member said, "When I am giving personal care I close the door. I always ask for their [people`s] consent." Another staff member commented, "We must treat people as individuals, I always offer choice with food and clothes. We must offer choice; it's important." Throughout our inspection we saw that staff sought to establish people's wishes and obtain their consent before providing care and support.

Care plans included information about a person's capacity and how they needed to be supported to make decisions. Written consent was sought by the provider, however, we noted that consent was not routinely reviewed as part of the care plan review. The provider told us about the resident of the day initiative where consent was covered and for the transfer from the paper to electronic care planning verbal consent was obtained from people or where appropriate their representatives. We saw that not every person or their representatives signed their consent at the time of the inspection.

Staff were aware and able to describe why people's capacity was assessed and when a DoLS was put in place to help keep people safe. We noted for one person with an authorised DoLS that there were conditions in place. We found that these conditions had been adhered to. For example, to ensure activities were developed to meet their needs and we saw that a plan had been developed and was reviewed monthly to ensure it met the person's needs but also respected their choices.

The home was designed in a way so that people could move around easily, whether this was independently or with the use of mobility aids. Equipment was well situated in bedrooms and bathrooms to enable people to be independent where possible. There were large comfortable lounges with ample seating for everyone and designated dining areas so people could enjoy a meal together if they wished. People's individual bedrooms included personal items to help create a homely feel. There was an accessible garden that people were seen to be using on the day of inspection.

Some people told us they liked the environment however at times their room had been filled with boxes and this was not to their liking. One person told us, "As you [inspector] can see my room is very spacious and I am very grateful for it. You can see around a lot of packages. I think they belong to me, my sanitary pads, creams, things which get delivered for me. But sometimes, staff comes and takes it for other residents and

they never ask or explain me what they are doing and I can't move my head to see what they are taking, maybe they are storing extra stuff here, I don't know so I do get a bit annoyed by that." Another person said, "What I might need to ask them [staff] and prompt them to do it is about all this stuff I receive in boxes. I like things to be put away and not to see boxes, not because I am super tidy but they are in my way when I am moving around. Staff will do it soon I ask them."

At the previous inspection we found that people's nutritional needs were not always met. At this inspection we found that people were supported to enjoy a variety of food and their individual likes, dislikes and dietary needs were well known by staff. Staff were able to tell us about people's dietary needs and how they needed to be supported. For example, when supporting someone who was nil by mouth, receiving a PEG feeding regime and those who were diabetic or at risk of choking.

People we spoke with had mixed views about the food provided to them. One person told us, "Not long ago they introduced diabetic jams and they gave me a job to place them on the table, so happy to do that. We have now diabetic ice cream, it's very tasty." Another person said, "There are residents meetings, most of the time is about food, people have a lot of problems about it, so I like to skip that subject." However, the provider was able to demonstrate, however, that there were regular food forums for people to discuss issues around food which was chaired by an operational member of staff from the catering company.

On one unit staff were trialling a new approach where the kitchen staff were responsible for serving the food and the care staff offered visual choices to people. Staff served smaller portions of all the choices available so people could taste and this was the same for the deserts. The registered manager told us this was a success and they were planning to roll this out through the home.

Dining areas had been given a purpose with nicely laid tables, condiments and cutlery and at meal times the atmosphere was relaxed and pleasant.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people's needs. We reviewed the overview of people's weights and saw that they remained stable. However, some relatives told us they felt they had to visit daily to ensure that their relative's received appropriate nutrition. One relative said, "[Person] has a brain condition and one of the symptoms is dysphagia. The speech and Language Therapist (SALT) recommended "fork mashable food" but kitchen staff is not cutting it up properly so we come every day to feed them. We think [person] is not safe eating unless we chop it again after it's delivered from kitchen. Also, [person] can't eat big meals and they get tired quickly, but again unless we are with them to give them something in between [meals] I don't think there will be anyone to assist, so we are here every day." The provider gave us with evidence that although they acknowledged the views of the relative, the food had been provided to fork mashable consistency in line with national guidance and they had regular communication with the relative around this issue.

We saw that people were offered regular snacks and had access to a range of drinks throughout the course of the day. Food and fluid intake was monitored and recorded. Generally, people were weighed monthly, unless there was a concern with their weight in which case they were weighed weekly. The chef manager told us how they catered for people who required specialist diets. They told us that when a person moved to the home a nutritional information sheet was completed. This form detailed any special dietary requirements for a person and if there were any changes a 'daily dietary change form' was completed by care staff informing chefs of the changes. They then provided the necessary food supplements such as fortified, pureed, or culturally appropriate meals such as kosher and halal for people.

Since our last inspection the CCG and the local authority worked closely with the registered manager and the nursing staff in Forest Care Village to ensure that people`s changing health needs were identified in a timely way and appropriate referrals were made to health professionals when it was needed. There were regular MDT meetings organised with representatives from the CCG as well as nursing staff and the registered manager where people with significant health needs were reviewed to ensure their health could be maximised.

When people were admitted to hospital when they were discharged following a protocol agreed with the Local authority, CCG, the provider and CQC where people`s condition was reviewed by the CCG or Local Authority within 48 hours of their return to the home and were seen by their GP to ensure any changes in their needs was clearly known and care plans were updated accordingly. The service is yet to demonstrate sustainability in this area after the existing protocol will come to the end. This would happen when CQC assessed that the provider made sufficient improvements to have the imposed condition to vary the providers registration with positive conditions and restriction of admissions imposed in December 2017 lifted.

People told us that they received good support with their health care needs. The provider employed a team of physiotherapist, occupational health therapist and speech and language therapist to ensure that people with assessed needs for these services could access these on site. People told us they had support from the provider`s physiotherapy team and GP.

## Is the service caring?

### Our findings

At the last inspection people had mixed views about staff being caring towards them. We also observed that people's dignity and privacy was not always promoted by staff. At this inspection people told us they felt staff were kind and caring and their privacy and dignity was protected.

Staff were calm and friendly with people and we observed them interact with people in a warm and caring way. We found staff to be kind and attentive and also communicate well with people. For example, we heard a staff member be calm and listen to a person, and repeat a task they had already done as the person asked for it again. They did this with a smile and were courteous throughout.

People told us staff respected their privacy. One person said, "What I like is that my carers, while they do like to "keep an eye on me" are not intrusive and will very politely excuse themselves but be there if I need them. We really have special relationship. They also take privacy and confidentiality very seriously, so I know I can trust them. Nobody will come inside my room without invitation." We saw staff promoting people's dignity and privacy by knocking on people's doors and waiting before entering people's rooms. Staff could tell us how they promoted people's dignity and respect by closing doors and good communication. One staff member said, "We always tell people what we are doing and respect their decisions all the time. If they [people] say no then we will try again later to see how they feel." People's records were stored in a way to promote confidentiality for people who used the service. However, one person had 18 posters with care instructions, included photos of them demonstrating how a splint should be put on, were displayed on their bedroom wall. This may ensure that staff know how to deliver safe care but it did not protect the person's dignity or privacy.

Staff also understood the importance of promoting people's independence. One staff member commented, "We encourage people to do as much as they can for themselves." Another staff member said, "If they can only use one hand then I encourage them to use that hand or they can lose the ability." People were cared for and supported in a kind and compassionate way by staff that knew them well and were familiar with their needs. Staff could tell us about the people they supported and knew about their preferences and cultural beliefs. For example, we looked at people's care plans and quizzed staff about the details of that person, staff demonstrated they knew the person well.

We saw that staff had developed relationships with people they supported. Staff knew people well they could tell us about people's preferences and likes and dislikes. People were also encouraged to develop relationships. One person said, "I feel that people [in the home] are nice, I have friends here, and we often go downstairs for coffee, to sit in the garden, or they come to watch a movie. The staff are my friends and they are young energetic, hardworking people, and I know they will do anything for us. This is comforting, not just for me but for my family as well."

People also had key worker whose role was to ensure they had the things they required and spent time learning what they wanted. One person said, "I have a key worker. They are hardworking and doing a very good job for me." The person continued to tell us how their key worker helped them writing cards to send to

their relatives.

People and relatives where appropriate, were involved in planning their care. We saw letters inviting relatives to be part of the review process. We noted that the resident of the day review process included spending time with people to ensure they were happy with how their care was delivered.

## Is the service responsive?

### Our findings

At the previous inspection we found that the provider's systems and processes had not ensured that people received care and support in a personalised way. People did not always receive personalised care and this was delivered in a task led way. Care was not always based on individual wishes, needs and choices.

At this inspection we found that significant improvements were made in this area, however further improvements were needed to ensure every person felt listened to and received care in a personalised way.

Since our last inspection the provider implemented electronic care plans. This enabled staff to see what needed to be done and they could update their actions as completed for example if someone had their meds or had been supported with personal care this could be updated and any relevant notes added. Staff told us that this saved them time and as a result had more time to spend with people. The system allowed the senior staff and unit manager to monitor and ensure people received their support and care. One staff member said, "The electronic system is a good one, I have more time with residents." Most people and their relatives had been involved in developing people's care plans and we found that the care plans were reviewed regularly to help ensure they continued to meet people's needs. We saw that people's relatives were kept informed about matters that affected people's care, support or wellbeing. For example, where a person's health had declined. Most plans included detailed information which clearly guided staff on what people's needs were but also their preferences, likes and dislikes. There was also information about their life history and families. We tested staff's knowledge about people's preferences, likes and dislikes and also risks and they were able to tell us what we wanted to know.

When staff didn't know, they checked on their hand-held devices which demonstrated that the information they needed to support people appropriately was readily accessible.

The review process of the care plans however was on-going and some people and relatives told us they had not been involved fully in regularly reviewing their care plans. One person told us, "My care plan was reviewed a very long time ago, maybe when I just came here and I think I am greatly improved [since moving to the home]. I had a lot of professionals involved [in the care] so I am much better now. I hoped they [staff] will suggest meeting before [a whole] year, as it should be done as soon my needs change."

One relative told us about a person who had specific needs when they were supported to eat and drink. However, the relatives clearly not participated in the care planning process as they told us, "I don't think there is much details about [person's] routine written in the care plan." Another relative said, "We did try to make few suggestions about [person's] care, but all have gone unanswered. When we ask when we will hear back, they would reply that it's been considered and that would be it." The provider implemented a 'resident of the day' initiative which meant that for every person a review took place at least once a month. This involved a full review of the person's care needs and asked for feedback from the person and relatives on the care plan. Where relevant relatives had been invited to attend these meetings.

We also found that in some instances there was a delay in updating relevant sections in the care plans when

people`s needs changed. For example, one person lost weight and their body mass index (BMI) changed. The person received fortified diet and they were on food supplements. However, the nutritional assessment had not been updated to reflect the weight loss and the changed diet and described the person having average BMI and normal diet. For another person one section of the care plan detailed that the person could mobilise with the use of a Zimmer frame and they were also on a normal diet. Another section in the same care plan detailed that the person could no longer mobilise independently and they were on a soft diet. Whilst the staff members we spoke with were aware of these changes there was a risk that some staff may have followed the wrong guidance. The provider told us that they would raise this immediately with the electronic care planning company, however this was an area in need of improvement.

People's religious beliefs were supported and there were regular services people could attend if they wished. However, we found that care plans needed further developing in this area to ensure staff had clear understanding how people`s cultural and religious needs and beliefs impacted on day to day care and their death. For example, a person`s care plan detailed their religious belief and cultural background, and that they liked everything about their culture. However, this has not been detailed in the care plan for staff to understand what this meant. The provider told us after the inspection that they identified a culture and spirituality lead in the home who would be developing this area.

People told us that their needs were met. During the inspection we observed staff being prompt in supporting people and responding to their needs in a way that confirmed they knew people well. We noted that people were clean and comfortable.

The service provided end of life care for people. The staff had been prepared for this by ensuring people had their wishes documented in their care plans. Care plans showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes. Where people were nearing end of life action was taken to keep them as comfortable as possible and to remain at the service if this was their choice. There were medicines prescribed 'just in case' for pain or anxiety. We saw a thank you letter from a relative of a person who died which stated, "I want to express my sincere gratitude for the wonderful, caring and considerate way my [relative] was treated whilst at the home. I am especially grateful for all the support we received in the last few weeks of [their] life."

People told us they were supported to engage in a range of arts, crafts, and hobbies that were of interest to them. There were singalongs', musical events, sporting events and outside entertainers visited the home. People were also supported to attend community events. There was a dedicated lifestyle team. Their role was to get to know what people enjoyed doing, spend time with people in groups or on a one to one basis when people were cared for in their rooms. There was a 'People like me' and 'Making moments matter to me' theme through their work and this helped them tailor what they delivered to people's individual needs, abilities and interests. There had been a recent canal boat trip and two more were planned.

Relatives had mixed views about the engagement opportunities provided to people. One relative told us, "My [relative] will be able to cope with only a few minutes of any activities, they will ask to leave whatever is going on, so it seems they [staff] do understand that. We usually take [relative] for a walk around, but second corner and they want to go back, so we keep trying." Another relative said, "What I think is that there are not much meaningful activities for people with very limited concentration and interest. People are dressed in the morning, brought down to this so-called café and then newspapers and cup of tea placed on the table in front of them." However, we found that this was an area the registered manager and the provider was still developing and constantly improving.

Complaints and minor concerns raised had been investigated and responded to. We noted that when a

complaint was received an action plan was developed to help ensure all remedial action was taken. There were responses and meeting notes within the complaints folder which demonstrated people had been listened to. However, we did note that some complaints relating to care and cleanliness had repeated indicating that the actions for addressing these had not been as effective as they had planned.

The provider had a survey where people were asked for their views. We saw that there was an increase in positive feedback over recent months. For example, in March 2018 a survey had some responses that stated people disagreed with the statement that they were involved in planning of their care, or that they would recommend the service to others and there were negative comments about staffing levels. In April 2018 of the 16 responses we saw that this had improved and in May 2018 only 2 people of the 18 people that had been surveyed listed staffing as 'neutral' response meaning that they neither agreed or disagreed.

There were resident and relative meetings where people decided on menus and activities and were asked for their views on the service. Some people told a member of the inspection team that they felt issues raised at meetings, such as comments about food, were not actioned. However, the provider gave us evidence of regular food forums and we saw evidence of when the provider had made positive changes as a result of people`s feedback. There were also posters displayed advertising an electronic tablet so that people could skype their friends and family.

## Is the service well-led?

### Our findings

When we last inspected the service on 05 December 2018 we found that not all the people living in Forest Care Village received care and support in a safe and effective way. There was a significant difference between the care and support provided for people who were clearly able to communicate their needs and wishes to staff and people who had higher care needs and were unable to make their wishes known. The quality audit systems in place were not effective and had not identified and resolved the issues found in the inspection.

Following the inspection, we issued an Urgent Notice of Decision to vary the conditions on the provider's registration. We imposed positive conditions on the provider's registration where we set out how we expected them to meet the regulations and also restricted admissions into Forest Care Village to give the provider and the registered manager time to implement the changes and improve the service.

At this inspection we found that significant improvements were made in all the areas we reported concerns about, however the actions, systems and processes put in place by the registered manager and the provider were yet to prove that the service could sustain the improvements achieved.

In addition, there was extensive support provided by the Local Authority, CCG and other partner agencies involving regular health and social care professionals visits to support the provider to identify where they needed improvements and agreed actions were put in place to improve the quality and safety of the care provided to people. The improvements were closely monitored and regular meetings were held part of the service improvement process led by the local authority. The provider and the registered manager worked together with all the professionals and implemented systems and processes which led to the improvements we described in the report. The Local Authority and the CCG partially withdrawn the support when the assessments carried out by them indicated that people received safe care and support. They will continue to monitor the sustainability of the service through regular multidisciplinary meetings and care reviews.

We saw there was a good management structure in place on the units. The unit managers had a good overall picture of what was going on and on each unit there was a senior who monitored and checked that the daily required tasks were completed by staff. They also communicated between the units to ensure the correct support was in place and staff confirmed that team work was good.

Staff we spoke with confirmed there had been positive changes since the last inspection. One staff member said, "We have had a lot of changes like the care plans and the dining experience. It is a better place to work." Another staff member said, "Yes there has been a big change. We are now working better as a team, the communication is better. The electronic system is a good one I have more time with residents." Another commented, "I have been here for three years it's a good place to work. We are now doing a lot of things for the residents. We take time to chat about their life experiences. They tell you all about their experiences. It's improved a lot, we started "meaningful moments. We make sure we see them [people] every day. It gives us much more time [the electronic care planning system] to spend with residents, it saves lots of time and is easy to use. We have good team work, I feel supported and my line manager is a person you can rely on."

Systems had been developed to identify shortfalls and address these areas as needed. Communication through the management team had been improved. There were monthly clinical and quality meetings to discuss all areas of the service, internal audits completed and any incidents that had occurred. This enabled the management team to review previous and ongoing action plans to help ensure they were effective. We noted that most actions were signed as being completed and we saw this to be the case. For example, an action was to provide staff with training for oral suctioning. We saw that these training dates were displayed and some staff had already attended the training. There was a log of regular multidisciplinary team meetings to ensure that the management team had a clear overview of the needs of the people they supported.

There was a home review audit completed monthly. This included checks of the environment, reviewed care records, tested staff response to call bells, reviewed action taken in response to falls and incidents and tested staff knowledge. There was a positive and negative observation column. Where issues were identified, an action was developed. For example, where staff had not had clear knowledge about safeguarding people from abuse, further training and then additional checks of their knowledge were completed. This had been effective as staff were all able to tell us how to recognise and respond to abuse. One staff member told us, "Things are better now, they are trying to improve all the time. Communication, teamwork so much better. The manager is leading us, advising us, here all the time for us."

Throughout the home we saw that the current rating was displayed along with the current action plan stating how management and staff were addressing the shortfalls and duty of candour guidance. There was also clear information about who was responsible for the home, the unit and contact information. One relative told us, "We received the leaflet about when we can speak to the registered manager, that was not long ago, they never said anything like that before, it would be nice to see if they will listen".

Some people and relatives were not as complimentary about the management in the home. They told us they tried to talk to the management however they were not satisfied with the actions or the response they got and they told us they lost confidence in them. We discussed this with the registered manager to ensure that they could further develop their relationship with people and relatives. We also saw that there were a number of initiatives in place for people able to attend meetings, that have been planned to be flexible and meet people's needs, but further work was needed to reach people who spend their day in their room or in bed.

Following our last inspection, the provider implemented an electronic care planning system to help ensure that people's care plans were up to date and that they could easily generate various reports to help them manage the service effectively. We found that generally care plans were well developed and contained personalised information about people, however in some instances various sections of the care plans contained conflicting information. The provider told us that they would raise this immediately with the electronic care planning company so this could be resolved. The care plan side of the system was fully functional, however some parts of the care planning system were still being developed to full capacity. We also found that the system generated alerts in case a task allocated to staff regarding a person was missed or in case tasks marked requiring two staff members were only marked as done by one. The registered manager told us that senior care team leaders and unit managers should monitor these. However, we found that the system flagged on the day of the inspection that for four the use of hoist was carried out by only one staff member. The registered manager told us there were two staff members however only one recorded the task. This needed improvement to ensure that the data collected and checked by the management team was reliable and appropriate actions could be taken to address shortfalls.

The provider had a member of their operations team expert in the electronic care planning system and they

were daily in the home to ensure that any issues with the system could be addressed in a timely manner and they coached and mentored staff to develop their understanding of how to use this system effectively.