Aspen Village Limited

Forest Care Village Elstree and Borehamwood

Inspection report

10-20 Cardinal Avenue
Borehamwood
Hertfordshire
WD6 1EP
Tel: 020 8236 2000
Website: www.foresthc.com

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Ratings

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

Overall summary

This inspection was carried out on 01 and 06 July 2015 and was unannounced.

Forest Care Village provides accommodation personal and nursing care for up to 178 people aged 18 and over with a range of complex care needs. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

When we last inspected the service on 26 April 2013 we found them to be meeting the required standards.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005)

Summary of findings

(MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and

where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to

the local authority in relation to people who lived at the service and were awaiting assessment. Staff we spoke with were aware of their role in relation to MCA and DoLS and how people were at risk of being deprived of their liberty.

People told us they felt safe at the home. Staff we spoke with were knowledgeable about keeping people safe and reporting any concerns they may have.

We saw there were sufficient numbers of staff to meet people's needs, however some people experienced a delay in receiving assistance promptly

Risk assessments were in place for people and were appropriate to their needs.

People's medicines were not always managed safely as staff had not always ensured an accurate record was maintained for people who had their medicines covertly administered.

Staff we spoke with told us they felt supported by the provider.

People told us that they were asked for their consent and their choices were respected.

People we spoke with gave mixed views about the food at Forest Care Village.

People who used the service, their relatives and professionals were positive about the care staff provided to people.

People felt able to approach staff and the unit manager with any concerns they had and were confident they would be dealt with appropriately.

An accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment had not been maintained consistently.

The staff and management at Forest Care Village had good working relationship with other organisations and health agencies.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Information about identifying abuse was readily available, and staff demonstrated good awareness of responding appropriately to any concerns.

Incidents, accidents and serious injuries were reported, reviewed and analysed.

There were sufficient numbers of staff available, however staff did not always provide people with care in a timeframe that suited their needs.

Risk assessments were in place for people and were appropriate to their needs.

People's medicines were not always managed safely as staff had not always ensured an accurate record was maintained for people who had their medicines covertly administered.

Is the service effective?

Requires Improvement

The service was not always effective

Staff we spoke with told us they felt supported by the manager. Training records we looked at showed us some mandatory training had elapsed.

People told us that staff sought their consent when supporting them. Staff demonstrated to us their understanding of mental capacity and consent however did not always complete mental capacity assessments thoroughly.

People were positive about the food provided at the home, however people were not always offered additional helpings.

People had access to a range of healthcare professionals and referrals were made swiftly where these were required.

Is the service caring?

Good

The service was caring

People, relatives and health care professionals were generally positive about the care provided.

Staff demonstrated a good understanding of peoples care needs, and knew how to support the people they cared for.

People were treated in a dignified manner with respect by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People did not always receive personalised care that was responsive to their needs.

The provision of activity and stimulation was inconsistent and did not always

meet people's needs.

People's complaints were dealt with and responded to appropriately.

Is the service well-led?

The service was not always well led.

There was a robust risk management system in place to protect people against inappropriate or unsafe care and support.

People's care record were not always completed accurately and did not always reflect the person they were written about.

Staff and people spoke positively about the manager at the home and said they were supportive of them and kept them informed.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 01 and 06 July 2015 and was carried out by an inspection team comprising five inspectors. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us. We reviewed information relating to concerns that had been raised to us and also reviewed the provider information return (PIR). This is a form that asks the provider to give some key information about the service which includes what the service does well and improvements they plan to make.

During the inspection we spoke with 16 people who lived at the service, eight people's relatives, and 18 members of staff the registered manager and the provider. We received feedback from social care professionals. We viewed 11 people's support plans and documents relating to the management and monitoring of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said, "I do feel very safe here and have never seen anything bad go on. All the staff look out for us and I can talk to them about any worries."

We saw around the home that information was prominently displayed that raised people's awareness of abuse. Information was available to people, their relatives and staff to inform them of how to report their concerns to either staff or to organisations outside of Forest Care Village, such as the local authority. Information was not always available in an accessible format, for the people using the service whose first language was not English, or for those who may have sight impairment.

Staff we spoke with were clear on how to recognise signs of abuse, and how to report this. They told us that in addition to injuries or concerns, unexplained bruising or changes in people's demeanour was reported through the home's safeguarding process. Staff were aware of whistleblowing, and all staff spoken with told us they would have no hesitation in reporting a colleague they suspected of harming a person. The organisation had a dedicated email and phone line for staff to anonymously report whistleblowing concerns that was made available to all staff to report any concerns. One staff member told us, "We are like family, and If I thought someone may have harmed my family I would report it straight away."

We reviewed incidents and accidents that had been reported in the home which included safeguarding concerns. We saw that these were reviewed by the management team, and where necessary the appropriate referral was made to the authorities including CQC. Accidents, incidents, and safeguarding incidents were routinely reviewed by the unit managers, and further assessed by the registered manager. In addition, each month the provider compiled the number of slips, trips, falls, injuries, safeguarding allegations and deaths. They reviewed this information and provided feedback to the registered manager where they suspected themes, patterns or trends were appearing. The manager was able to use this information to review their care to keep people safe and ensure they provided appropriate staffing levels.

People we spoke with told us they felt there was usually sufficient numbers of staff available. One person told us, "When I press my call bell they are coming to help me." One person's relative told us, "They have plenty of staff, this is reassuring knowing people do not have to wait too long if they need assistance." We observed over our two days there were sufficient numbers of staff to support people. Call bells were answered swiftly, however we did observe that staff answered the call bell and told people they would return shortly. Where this was generally within one or two minutes where they were tending to another person, we did note sometimes this was in excess of five minutes. Where we were satisfied staff had initially responded to people, and checked they were not at risk, they had not always then provided care promptly to people. One person told us, "It is so busy here and staff don't have much time, but they always acknowledge you and check that you are ok."

Staff we spoke with gave us mixed opinions about the staffing deployment in the home. Some staff told us they felt there were ample numbers to support people, but others felt at times it was just simply some staff not carrying out their roles as expediently. One staff member told us, "Yes, most of the time there are enough of us [staff] but there are those who do and those who don't, and the days when those don't mean it's harder for us and we get to spend less time caring for people." Where people were unable to use their call bell staff regularly checked on them and documented this in their daily records. The manager and provider showed us examples of how they monitored and flexed their staffing levels, based upon the needs of the people using the service. For example we saw that one person due to be admitted on the day of our inspection had been assessed and provided with a one to one carer, because of their needs. We also saw that on the Glastonbury unit, additional staff had been brought in to provide one to one care to another person.

Risk assessments were in place for people and were appropriate to their needs. We reviewed some of these and found that they in many cases aimed to enable people to take risks, and that these risks were explained to people. For example, one person refused to allow staff to place protective covers, sometimes known as bumpers, on their bed rails to protect them from the risks of entrapment. Risk assessments clearly documented that staff had discussed alternative options with the person, explained the risks

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Is the service safe?

involved, and allowed them to make their own choice. A risk assessment was developed that detailed the preventative measures staff should take to minimise the risks.

Staff we spoke with told us they underwent a rigorous recruitment process. This included an interview process, criminal record checks, proof of previous qualifications and written references. This helped to ensure that staff employed were fit to work with people who were vulnerable.

Information, diagrams of the home and guidance about emergency procedures were displayed at various locations, together with equipment such as fire extinguishers and resuscitation devices which were regularly serviced. An evacuation plan was in place in the event of an emergency and regular environmental safety checks were carried out. In the event of an emergency, there were clear procedures for staff to follow to inform members of management. Staff were given additional responsibilities for ensuring people were kept safe, for example some staff were trained to be fire marshals.

We observed staff administering people's medicines and saw that this was carried out in a safe manner by nursing staff. One person told us, "Staff are really good at helping me with my medicines." Where medicines had been administered, staff had recorded this with no gaps or omissions and stocks of medicines tallied accurately with records of the numbers which had been dispensed.

Medicines were kept stored in a locked room; however this room on the day of inspection was cramped, untidy and overstocked. Staff we spoke with told us this was a temporary measure whilst space was created for a second medicine room that was due to be used shortly. Staff ensured that people's medicines were stored within safe temperature ranges, and checked the medicine room and fridge temperatures daily.

Medicines were not always managed safely for people who had their medicines covertly administered. We looked at the arrangements for managing covert medicines, and saw in two people's medical records staff administered medicines covertly. Staff had sought the advice of a GP, and where appropriate informed people's relatives, however they had not sought the consent of a pharmacist. The consent of a pharmacist is key to ensure that any changes to people's medicines, such as crushing tablets or altering the route, is safe and does not affect the manner in which the medicine is absorbed. The provider demonstrated to us subsequent to the inspection, but as a result of our findings, they had reviewed people's covert medicines with a pharmacist who had given this their approval.

Staff we spoke with told us they had received training to administer medicines, and that their competency had been assessed as part of their ongoing supervision. Where staff were required to administer medicines through devices such as syringe drivers or PEG feeds, they had been provided with additional training.

Requires Improvement

Is the service effective?

Our findings

People and their relatives gave us mixed views about the staff's ability to perform their role. One person told us, "Some [staff] are really good, been here for ages, and some are newer." One person's relative said that they found staff were, "mostly good" but said, "The skills and abilities varied." They went on to say, "Some staff do not use their initiative to encourage their relative to do things."

Staff we spoke with told us they felt supported by the provider. They told us they were required to carry out an induction that followed a nationally recognised framework. They said that they shadowed an experienced member of staff, and senior staff members assessed their competency prior to them providing care to people alone. One staff member said, "The induction is quite full on, but it covers what we need to know to get on with the job."

Staff told us that they received frequent supervision with their line manager where they were able to discuss matters relating to work, and also any personal concerns they had. Staff told us that they were actively encouraged to undertake additional training to aid their development. One staff member said, "The training is really good, I am about to start a QCF [National qualification] level 5, and if I wanted to attend a course in neuro, or brain injuries I could, I just have to ask." The training manager told us they were committed to ensuring all staff were able to access areas of higher level training, and provided us with examples of staff who they had put forward for further nationally recognised training. They told us that it was the policy of the provider to support staff development and encourage development for inward career progression.

However they also told us that they were in the process of reviewing the training for the home, and that as part of this they had asked for the unit managers to ensure observations of people's practise were recorded and reported to the training team. This meant that where training needs were identified as they were observed, staff could be retrained quicker which reduced the risk of poor practise. We saw from training records that areas of training identified as mandatory for staff each year had elapsed, such as moving and handling, by a number of months in many cases. We spoke with the training manager, who showed us a robust training plan they were developing. They told us areas they were developing were to, "Have 80% of carers trained to a nationally recognised qualification in care," and also, "To provide literacy courses for staff where English is not their first language." In addition to this the provider and manager assured us that all staff would have received required refresher training within a three month period from the date of our inspection.

People told us that they were asked for their consent and their choices were respected. We saw staff offering people a choice of options and explaining what was happening next while supporting

them. For example, what they wanted to eat or drink, whether they were ready for their personal care, or wanted to get up for the day. One person told us, "We always have a choice; nobody makes us do anything we don't want to do". However when we looked at people's care records not all showed how consent had been obtained. In the minority of care plans we looked at people had signed to confirm they had consented to their care, support or treatment. Some care records had a 'residents/relatives involvement' form but this recorded contact rather than consent. We spoke with the provider about the quality of people's records and they told us personalising and ensuring people had complete records was an area under development and review within the home.

Staff demonstrated a good understanding about MCA & DoLS. One staff member said, "It's about knowing when a person can or can't make their decision, and for us to understand how we can help them when they are unable to." However a visiting professional told us, "They [staff], try to fit everybody under one hat, there are too many restrictions for the people without a voice. There is room for improvement." This was not generally our observations of the day, as on the ground floor we found that MCA and best interest decisions had been followed. However on the residential nursing and dementia units we found there were errors and omissions, and the Mental Capacity Act 2005 had not always been followed.

We saw that where people had been identified as not having capacity to consent, particularly on the first floor and dementia unit, records demonstrated that staff had not always followed the appropriate protocol with regard to assessing capacity. For example, when we reviewed the care records for one person with dementia, we ascertained from the nurse and unit manager that the person lacked mental capacity in their opinion. We asked to see a copy of the capacity assessment, and was provided with blank

Is the service effective?

sheets in the person's care record that had yet to be completed. Throughout our inspection on these units we noted other examples where capacity assessments were missing or had not been completed appropriately. However, where the process had been followed appropriately, we saw people's capacity had been assessed where required, and involved an Independent Mental Capacity Advocate where this was needed. We explained to the provider that there was an inconsistency in the initial assessment of people's capacity by staff across the different units. The provider subsequently after the inspection sent us information demonstrating to us they had implemented a new format of their assessment tool, and would review those people who required this.

The manager had made the necessary DoLS applications and was waiting for an outcome for the local authority. Whilst we carried out our visit, a DoLS assessor attended the home to review one person's needs at the request of the manager. However, where possible we saw staff utilised the least restrictive option to keep people safe, for example using low profile beds and padded mats for people at risk of falling from their bed.

People we spoke with gave mixed views about the food at Forest Care Village. One person told us, "The food is 'so so', the caterers are OK but a lot of food gets wasted. We get about six choices [of meals]." A second person told us, "The food is better than at home, I have no complaints about it."

We observed lunch in various dining areas across the home. Tables were presented nicely with cloths, place mats, proper cutlery, flower decorations, menus and plenty of juices and water. We saw there was a range of fresh fruit provided to people that they could help themselves to and a range of snacks were available throughout the day. We saw whilst we spoke with kitchen staff one person come to the kitchen and ask for a mixture of bananas, apples and oranges. The kitchen manager told us this person and a number of others frequently asked for fresh fruit to supplement their diet. We observed that people enjoyed their food, and generally there was a friendly sociable atmosphere in each of the dining rooms. People were encouraged to eat independently were they could, and aids were provided to support this. We saw at lunchtime across the home there were more than enough staff to cater for people's individual needs. Those who required support to help them eat and drink were provided with it in a calm, patient and relaxed way.

We did note however, that on the upper floors of the home, people were not offered second helpings of their meal once they had cleared their plate. People's meals and desserts were also brought onto the units at the same time. On the day of our inspection we saw that ice cream had been left on the worktop, which had melted considerably by the time people had eaten their first meal. We asked why desserts could not be sent separately, and there seemed to be mixed feelings about how this could be managed. Kitchen staff told us they didn't have an issue with one of their team delivering desserts to ensure they were fresher.

People's weights were regularly monitored, and each month these were reviewed by the home manager. Where people were losing weight the appropriate actions were taken. We spoke with the kitchen manager, who told us they routinely fortified people's meals with creams and cheese, but would additionally fortify a person's meal who staff identified as suffering weight loss. However, we were told that kitchen staff did not feel they were always informed about people's weight loss or specific needs such as diet or allergy requirements when required. We were told, "I don't always get people's nutritional assessments, they [staff] will come down and say they can't eat this because they are allergic or diabetic." This meant that there was a risk that people may be given food that they are allergic to, or that may not meet their specific needs.

People however did not always have their fluid records maintained accurately. We saw throughout our inspection that there was a range of drinks available at all times, and staff encouraged people to constantly drink. However, they did not always record this on a person's fluid chart. For example, we observed one person at lunchtime who had been recorded as having 100ml of fluid since they woke that morning. However, the observed volume of juice they consumed at lunch was far in excess of 100ml and had not been added to their record.

People's day to day health needs were met. Upon arrival at Forest Care Village we observed the morning staff handover from night shift to day shift. This was on Glastonbury unit where people have a range of complex needs. We saw 16 carers and five nurses attend the handover, where information about people's health and support needs was given. Where there were concerns about a person's health, this information was discussed and allocated to a specific team to follow up. For example, staff discussed how one

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Is the service effective?

person's catheter was blocked that morning which had been cleared but asked for this to be monitored. Where people had appointments at local clinics and hospitals for appointments or surgery, staff were made aware.

Referrals made quickly to relevant health services when people's needs changed. We saw numerous examples where people's physical or mental health had deteriorated and appropriate referrals were made to GP's, speech and language therapists and physiotherapists employed by the provider, and also to external professionals such as nursing teams, psychiatrists and specialist consultants. The home also had arrangements in place for chiropodists, hairdressers and opticians to visit.

Good

Is the service caring?

Our findings

People who used the service, their relatives and professionals were positive about the care staff provided to people. One person told us, "It's really good [here], like being with family all over again." A second person told us, "I like it here, prefer it to home. The staff are alright, I get looked after pretty good." One person's relative told us, "In all honesty, every staff member in this place knows me, my family and friends who visit. They [staff] are fabulous, so friendly and polite."

We saw that people were smiling and comfortable in the presence of staff. Staff demonstrated an understanding of each person they were supporting and spoke to them in a manner the person understood. We observed staff approach people sensitively who were hard of hearing and talk softly, using objects of reference to explain what they wanted to say. The day of our visit was very hot with bright sunshine. One person was about to leave the home to visit local shops. A staff member approached and encouraged the use of sun cream and a hat to protect them in the hot weather taking time to explain the reasons why. They then offered to go back to their room and support them to find a suitable hat and help apply the cream. They helped the person find sun cream and explained the importance of using the right 'factor', particularly as the resident had fair skin. They then helped them to apply the cream in a kind and gentle way, explaining why it was important to ensure that exposed areas were covered. We saw another staff member offer to help a person who had misplaced their reading glasses look for them, kind and patient words of reassurance were used such as, "Don't worry, I'm sure we will soon find them," which helped to reassure the person and allay their anxiety. One person's relative told us, "People are encouraged to forge positive and meaningful relationships with other people at the service and also with the staff."

People told us that staff were approachable and willing to listen to them about their care, support and any concerns they had. One person told us, "I teach them [staff] my way of doing things, they are caring for me as a person, not just the same as everybody else. They need to know about looking after me." A second person told us, "The staff are great here; I can talk with any of them." One person's relative told us, "They ask about the little things that are important [relative]."

People we spoke with told us that both care staff and nursing staff took the time to explain to them their options about their care. One person told us, "It was just a little while ago that I had to have a small procedure, I didn't want to have it, but the nurse took the time to reassure me and give me all the information I needed to decide." A second person told us, "I know what they [staff] are doing and why, and if I want to question them they answer." One person's relative told us, "Communication is very good, if there are any changes to [relative] they tell us straight away and explain what is needed to be done."

People and their relatives told us that staff ensured they were treated in a dignified and respectful manner at all times. One person told us, "They always knock on my door." We saw bedroom doors were closed in accordance with people's preferences. When personal care was delivered people's bedroom doors were closed and in addition the home had a visual warning system in place for other staff and visitors. Outside and above the bedroom door was a green light to clearly indicate personal care was delivered. This helped to ensure that visitors or other staff members did not intrude when a person may be undressed. We also noted that when people were offered the toilet this was done discreetly.

People were supported to make advance decisions in relation to their end of life treatment and appoint someone with lasting powers of attorney where they wished to do so. We saw copies of advanced directives gave clear guidance about how the person wished to receive their care, and nursing staff we spoke with were aware these were in place. One visitor who had recently experienced a bereavement returned to the home told us "They are brilliant here, they looked after [person] very well, they offered support to us [family] throughout hard times and nothing was too much trouble."

Requires Improvement

Is the service responsive?

Our findings

People and relatives gave us mixed views about being involved in the assessment of their health and support needs. One person told us, "I feel that I am involved as much as I can be, they make notes and seek my views on how I want to be treated. A second person told us, "It depends on whose working, some of the girls care for me the way I would myself, but some must go through the same routines with everyone." One professional told us, "It is not really person centred it`s more institutional."

We found that the feedback across the home was mixed, and dependent upon which unit people lived in. The views of people living on the ground floor where very positive and we saw that in the majority of examples, people received personalised care that met their individual needs. However, when we observed care on the dementia unit for example, we found this was not always the case. Although people had comprehensive care plans their involvement in the design of their own plan of care was not always promoted. One visitor said "I had no involvement in [relatives] care, they [the staff] never asked."

The provider had sought the support of a dementia consultant to assist with developing people's care plans across the home. We saw that in many cases this dealt with identifying 'behaviour plans' for people who had displayed anxious or aggressive behaviour for example. We reviewed two of these care plans and saw that incidences of 'challenging behaviour' had simply been recorded and reported to the unit manager. Staff we spoke with did not demonstrate an awareness of people's unique personalities and histories to aid them in understanding the person. Our observations showed that people were not provided with appropriate individualised care to positively support people's agitation and restlessness consistently.

Staff we spoke with were not all able to describe to us people's needs, preferences, and interests. For example, we asked one staff member to tell us about a person, what they liked, their family history, their preferred routines, but they were unable to tell us. However when we spoke with a second staff member they were able to give us an in depth insight into this person's history. Where staff did not have an awareness of people's history, this meant that some people, particularly those living with dementia, were not supported in a person centred manner. For example, one member of care staff told us how one person used to have a career which was centred on caring for and supporting people. However we observed at lunchtime that when they got up whilst eating their lunch to assist another person, they were told to sit down and eat their pudding by clinical staff.

We spoke with the lifestyle manager, who supported people accessing a range of activities. On the day of our inspection, the main atrium in the home was lively, sociable and people who attended enjoyed the range of activity provided. We saw that common activities for groups of people were a coffee morning, newspapers, music, live singing, scrabble and a pampering session. We were shown where staff had dressed up in fancy dress and residents had judged the competition. The lifestyle team had access to a minibus, and trips were planned for day trips to go shopping or visit attractions. However, we did not see any activity provided to people who were unable to get out of bed, or for those who chose to not join in with the community activities.

People's care records did not always contain sufficiently detailed personalised, information to assist staff to provide individual care that promoted people's preferences, wishes, and aspirations. Where staff moved around the home to different units, or where provided by an agency, this meant people were at risk of receiving unsafe or inappropriate care from staff who did not know their preferences. The provider told us that they were aware the care planning and at times delivery needed to be 'Person Centred' and this was an area they were developing. The provider, staff and some people told us about an initiative being trialled in the home. This was called 'People like me,' which we were told was a tool that promoted effective communication between staff and people. The provider told us the core of this new approach was that both staff and people shared common interests. It was the responsibility of staff to find people who were like them, and then to share and develop those interests. Staff told us that it was a positive development that in its infancy had enabled them to connect with people in a more personal manner.

People's complaints were dealt with and responded to appropriately. People told us they knew how to complain, and had been provided with a copy of the provider's complaints policy. Information about the complaints process was displayed at various locations around the home for people to read through. Most people we spoke

Requires Improvement

Is the service responsive?

with told us they had no hesitation in reporting their concerns to management when needed. However some people told us that on one unit they did not know who the manager was. This was due to recent management changes in the home, however they also told us they would report concerns to the registered manager. However people told us that their complaints were dealt with swiftly and they were informed of the outcome of any investigation. One person told us that they had made several complaints to the unit and registered manager, but were not satisfied with the outcome. We reviewed this complaint and saw that an investigation had been conducted, however as no satisfactory outcome could be found; they had further referred the complaint to the senior management team, and local authority.

People felt able to approach staff and the unit manager with any concerns they had and were confident they would be dealt with appropriately. One person told us they had told the manager they witnessed staff arguing on the floor which they considered unprofessional. The manager listened, took the matter seriously and spoke with the staff concerned.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us that the home was well led. People, their relatives, and healthcare professionals told us the manager was approachable and responsive. One person told us, "They are extremely approachable; I can stop the manager any time and discuss my grumbles with them." One healthcare professional told us, "There is more confidence in the management and that any concerns will be properly addressed by the Village Director and taken seriously."

People's records were held securely and staff were aware of how to keep people's information safely. However, people's care records were not always completed as required. We noted on numerous occasions that people's food and fluid charts had not been updated to reflect the amount people had eaten or drunk that day. For example, we saw one person with a large beaker of water that was continually topped up. This person had been assessed as requiring their fluids recorded in millilitres. However when we looked at the record throughout the day, we saw this was vastly below what the person had consumed. This meant an accurate record had not been maintained for people which could impact on decisions about their future care and treatment.

We saw that where people lacked capacity to make certain decisions, staff had not completed the required documentation comprehensively with a clear record of how the decisions were made. From records we looked at it was unclear if staff had sought the views and opinions of relatives, professionals or the person themselves. We saw that some care plans did not indicate that people had been involved or authorised their care. Details about people's backgrounds, life story, employment, families, events, aspirations had not always been incorporated into people's assessments and plans. Care plans were detailed and covered a wide range of clinical areas such as nutrition, medicines, and risks etc. but were not completed in a person centred way. For example they did make it clear that a person needed two staff to assist with washing someone in the morning, but nothing about the manner in which they preferred to receive this care or how they would like to be supported.

We found that one person needed hourly checks as part of their care. Records indicated that a check had not been carried out for three hours. We spoke with care staff and a nurse who were able to demonstrate through tasks completed that the checks had been made, but that they had forgotten to complete the monitoring record.

This was a breach of regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there were regular meetings to ensure information was shared as required. They said there were meetings for the unit manager's, as well as for teams such as the registered nurses and carers. Records of the meetings were maintained and demonstrated to us that staff were able to raise concerns, receive feedback on developments, and discuss matters relating to residents, among other areas. One person told us, "The manager is lovely, a very good manager. We see them every day. They listen."

A range of auditing had been carried out by the manager. These included areas such as incidents, safeguarding, complaints, occupancy, pressure sores, nutrition and staffing levels. The results from these audits were entered into the homes computer system, and reviewed by senior members of the organisation. In addition, the results were reviewed by the Chief executive officer, and formed the basis of a board report which was discussed on a regular basis with board members. Any concerns or issues that were identified were then fed back to the manager for action. We saw the manager had developed action plans to address areas that had been identified, and these were then constantly reviewed. The governance systems at Forest Care Village ensured that all levels of staff, management and senior management were aware of the risks present within the home.

Quality review meetings were held at the home on a rotational basis. This meant that the provider and members of the executive board held their quality review meetings within the home, and also ensured that they were able to review the home in person. We saw from extracts of board meeting minutes that areas discussed were reviewing pressure sores, recruitment, health and safety matters and implementing a new format resident and relative survey. This demonstrated to us that there were governance systems both in the home, and at the provider level that helped to ensure the quality and safety of the service was reviewed and monitored.

Requires Improvement

Is the service well-led?

We looked at the results of three resident surveys that were completed for April, May and June. We saw that these were in a standard format and also an assisted format for people to help those express their views where they were less able. However the proportion of returned surveys that were used was insufficient to gather a proportionate view of people's experience. For example, one month had gathered the views of eight people. We discussed this with the provider who told us they were in the process of redeveloping the resident and relative survey. They told us that in future, a greater number of people's view would be captured. We also saw that a food forum held to gather people's views about the food provided and suggest menu changes was also heavily under attended. For both areas, improvements are required to ensure that the maximum number of people's views are captured to reflect the needs and diversity of the home.

The staff and management at Forest Care Village had good working relationship with other organisations and health agencies. The local council who also monitors the service delivered told us that they had seen significant improvements in the home over recent months. Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (c) Good governance An accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment had not been maintained.