Embrace (South West) Limited

Sherwood Forest Care Home

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection visit took place on 6 October 2016 and was unannounced.

Sherwood Forest Care Home provides accommodation and care for up to 75 people, many of whom are living with dementia. At the time of our inspection, there were 60 permanent people and three temporary people in residence across the two units referred to as Forest View and Sherwood View.

The care home had two registered managers in post (one for each unit). 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 2008 and associated Regulations about how the service is run.

Most people received their medicine as prescribed and when they needed them. However, we found instances that some records were incomplete which may indicate that people had not received their medicine.

Some people were not adequately protected from potential abuse. We saw incidents had happened in the home and there were no evidence of how risks were managed to prevent occurrence of any future events. These issues had not been notified to us or the local authority.

We monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found the provider was meeting the requirements of DoLS because the registered manager had applied to authorise the deprivation of liberty for some people using the service. Staff had a variable understanding of the Mental Capacity Act 2005 (MCA). Records did not demonstrate that people's rights had been protected when they were assessed to lack capacity to make decisions regarding their care and treatment.

The registered managers had not carried out regular supervisions of staff had proper support and relevant competencies to care for people using the service.

People's dignity and privacy was not always respected or promoted. We observed sensitive personal topics being discussed by staff within a communal area. People requested assistance but staff had not responded in a timely manner, which compromised people's dignity. People who required glasses to maintain their vision were not provided with these.

People's care had been planned but the monitoring in place did not demonstrate that support had been consistently delivered. For example, whether they were supplied with drinks and had their weight monitored.

The registered managers had carried out audits to monitor the quality of the service and to make improvements. However these did not always demonstrate what action had been taken to address any

shortfalls identified.

The registered managers did not always notify us of events and incidents that they are legally required to do.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulation 2009. You can see what action we have told the provider to take at the back of the full version of the report.

People enjoyed the food and were offered choices. Staff used visual prompts to support people to understand choices available to them.

People told us they felt safe at the home.

People felt able to raise any concerns and were confident that the registered managers would take action.

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 consistently safe.

People may not have received their medicines when they needed them or as prescribed. Incidents that happened within the home were not reported to external agencies such as us or the local authority. Staff did not receive regular supervision to check they had the relevant competency and support to care for people. The service followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found that people rights under the MCA may not have been assessed in line with the principles of the Act. People were offered nutritious food and drinks. People had access to healthcare professionals when they needed. Staff had completed mandatory training.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect. People's confidentiality was not always respected. Staff did not always respond to people in a timely manner. Some people spoke positively about the care they received and about the staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to participate in meaningful activities. People felt able to raise complaints and issues with the registered managers. Visitors were made to feel welcomed and no restrictions of visiting times were in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Documentation of the care provided was not suitably monitored.

Audits that are designed to monitor the quality and safety of the service did not identify action taken as a result of any shortfalls they identified. The registered managers did not always notify us of events and incidents they are legally required to. People and visitors felt comfortable and able to approach the registered manager. Staff felt supported by the management of the service.

Sherwood Forest Care Home

Detailed findings

Background to this inspection

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

We last inspected this service on 29 March 2016 and we told the provider to make improvements in relation to assessments completed under the Mental Capacity Act and improvements around care records and risk assessments.

This inspection visit took place on 6 October 2016 and was unannounced. It was carried out by two inspectors, a specialist advisor with experience of nursing care for people living with dementia, 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 care service. The expert-by experience on this inspection had personal experience of caring for someone who is living with dementia.

Sherwood Forest Care Home is registered to provide nursing care and accommodation for up to 75 people and specialises in the care of older people. Accommodation is divided into two units referred to as Sherwood View, that provides care to people who require nursing care, and Forest View that provides care to people living with dementia. At the time of the inspection there were 60 people permanently living at the home, with one person on a short respite stay and two other people on 'step-down' from hospital. Step-down is when the hospital discharges people to receive personal care in a residential home whilst further long-term plans are put in place for their care.

The provider had previously completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including previous inspection reports,

statutory notifications (issues providers are legally required to notify us about), and other enquiries from and about the provider and other key information we hold about the service. We also received feedback from commissioners who fund care for some people.

We spoke with six people who lived at the home, two visiting relatives and five members of care staff. We also spoke with the two registered managers and the regional manager. During the inspection visit we spoke with two visiting healthcare professionals.

We spent time observing care practices and interactions in communal areas to understand how people received their care and support. We observed lunch being served. We looked at a selection of records which related to people's care and the running of the home. These included seven care plans, four staff personnel files, minutes of meetings and records relating to the quality monitoring of the home.

Requires Improvement

Is the service safe?

Our findings

People weren't always protected from potential abuse. Some incidents which had occurred in the home met the criteria for a safeguarding referral but had not been reported as required. We found during our inspection that four incidents including one alleged sexual assault between two people using the service had not been discussed with or reported to the local authorities safeguarding team in accordance with local and national guidance. For example, we saw also saw in records that a person displayed behaviours which some people might describe as challenging and threatened a member of staff. We saw that there was no learning taken from the incident to demonstrate how staff would safely protect the person in the future.

Staff had received training in safeguarding and were able to explain signs of abuse and how to report it. The provider had a whistleblowing policy in place and staff were familiar with the procedure. However these incidents had not been reported to the local authority safeguarding team or to us. Following our inspection, we alerted the local authority to our concerns.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the end of this report.

People were mostly happy with how they received their medicines. One person told us, "Staff makes sure I take my medicine." However, we found that people were not always given their medicines when they required them or when they were supplied to them as prescribed which meant it could impact on managing their health. The provider had a medicine policy in place and copies were available to staff. However staff did not always follow the procedure in relation to the administering of medicines.

We checked medication administration records (MARs) for eight people. We found that topical creams MARs were not always completed to indicate they had been applied. For example, we saw that one person's cream used for pain relief hadn't been applied for three days. Their records showed that they had been experiencing some discomfort and pain during that time. We spoke with the registered manager, who was unable to confirm whether or not the person had received their pain relief due to records being incomplete and the person was unable to tell us if they had had their medicine.

One person was prescribed medicine to be given covertly (disguised in food or drink). Their care records did not detail why their medicine was to be given without their knowledge. One member of staff we spoke with told us, "It's dissolved in a cup of tea," but they were unable to explain what to do should the person not take all their medicine. This meant that the person may not take all their medicine required to manage their health.

We saw that there was no specific information or guidance available regarding the administering of this medicine. We saw that a Pharmacist was not consulted with. We discussed this with the registered manager who advised they would speak to the person's GP and Pharmacist as soon as possible. We spoke with the registered manager the day after our inspection visit and they confirmed that the medicine is no longer being given covertly. This meant the person was now aware of their medicine and were able to take it as

prescribed.

Medicines were stored safely and securely. A suitable medicines storage area was available within each unit of the home. Staff used medicines trolleys to transport medicines around the home. These were stored in a locked room when not in use.

People felt there were not always enough staff. One person told us, "Usually I don't have to wait too long but it depends what they [the staff] are doing. If I ever want anything, they say, 'You'll have to wait.'" A staffing tool linked to dependency levels of people who used the service had been completed to ensure that there were sufficient staff deployed to meet people's needs. We observed that staffing levels were reflective of the tool. Staff we spoke with told us that they felt there were enough staff to meet people's needs. Staff were mindful not to leave communal areas unattended and we saw they communicated with each other to ensure someone was present to assist people when they required and to keep people safe.

The provider followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (police check) to make sure people were suitable to work with adults.

There were assessments in place where people had been identified as being at risk. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken by staff to minimise the risk to the person they support. They described the actions staff were to take to reduce the possibility of harm. Areas of risk included falls, moving and handling, malnutrition and pressure sores. These had been reviewed and evaluated regularly. Personal Emergency Evacuation Plans (PEEPs) provided information and guidance to staff in the event that people needed to be evacuated from the premises in an emergency.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, improvements were required in relation to assessing people's capacity as they did not relate to supporting people to make specific decisions about their care and treatment. Some people who lacked the capacity were also being deprived of their liberty and relevant legal authorisation had not been sought from the Supervisory Body. The provider sent us an action plan to inform us how improvements will be made.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and 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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions and authorisations to deprive a person of their liberty were being met.

People whose first language was not English had their capacity assessed in relation to receiving personal care. The capacity assessments identified where people lacked capacity to give consent, the decision was made in their best interest. Staff told us that they thought that one person had capacity and should be involved about decisions relating to their personal care. A staff member told us, "They communicate by showing things. I tell them, I am going to give them a wash and they understand." We spoke with the registered manager who informed us that the capacity assessment was completed in English as opposed to the person's first language. This meant that the person may have not understood what was being asked but staff were clear that the person was involved in decisions about their care as much as possible.

We saw that one person had been prescribed medicine covertly. The registered manager completed a capacity assessment which identified that the person was unable to consent to taking their medicine and it was in the person's best interest to have the medicine. However the capacity assessment did not document any rationale as to why the person needed this medicine. We also found that the person had their capacity assessed previously in relation to other decisions about their care and was found to have capacity to consent. Their care records did not contain any information that indicated that the person's health may have deteriorated between the previous capacity assessment and this most recent one which affected the way they could consent. Therefore it was unclear why they were unable consent to their care. We spoke with registered manager following the inspection visit who confirmed that they had reassessed the person's capacity. These found they were able to consent and are no longer receiving the medicine covertly.

People were supported by staff who did not receive adequate supervision (one to one meetings) with their line manager. Two members of staff we spoke told us they could not recall when their last supervision was. The provider's policy confirms that the registered manager should complete supervisions with their staff

every four to six weeks. We saw that most of the staff supervisions were overdue with one staff member being overdue by eight months. We discussed this with the registered manager and the regional manager. They told us that all staff had a supervision meeting scheduled but these had yet to take place. We saw that the documents used to record supervisions were the same for all staff and that no clinical supervisions were completed for the registered nurses who worked at the home. This meant that the provider could not be assured that staff had the relevant skills and competence to support people using the service.

People were supported effectively by staff that had undertaken relevant training. All staff we spoke with informed us that they felt equipped to carry out their roles and said that there was sufficient training. One staff member told us, "I am all up to date with my training," and staff records we looked at contained course completion certificates that covers a variety of topics such as first aid, moving and handling, and fire safety." Care staff were also supported and encouraged to undertake accredited training such as NVQs which is a work-based qualification.

People told us they enjoyed the food. One person told us, "The food is good. I can have bacon and eggs for breakfast if I want." We saw that people were supported to eat and drink at their pace. We saw that there was a weekly menu in place and people had the option of what they would like. Staff told us, "If they don't want what is on the menu, we can make them something else." We observed at breakfast time that people were offered choices such as cereal or toast with jam. One person had finished their cereal and staff were seen asking if the person wanted anything else to eat. We saw that the lunch time period was calm and staff were unrushed to support people to eat and were attentive to their needs. The menu written on boards within communal areas and pictures of the food was also displayed. We saw that people, who required specialist diets such as pureed or soft food, were provided with these.

People were supported to access healthcare services. For example, we saw in records that people attended appointments with their GP, dietician, speech and language therapist and dentists. The home also worked in partnership with a nearby GP practice, where people are mainly registered. People were given the choice of keeping their own GP or transferring to this practice when they start using the service. We saw that the GP did a weekly round in the home to see people as this reduced disruption and anxiety they may experience when travelling to the practice. Also the GP practice had appointed a Practice Nurse responsible for ensuring people get the right healthcare intervention when needed. They were available for staff to contact when they needed advice. This demonstrated that the expertise of appropriate professional colleagues was effectively available to ensure that the individual needs of people were being met to maintain their health.

Requires Improvement

Is the service caring?

Our findings

We saw that people's dignity and privacy was not always respected or promoted. During our inspection visit, we observed a visiting healthcare professional, a staff member and the registered manager discussing a person's end of life wishes with them in a communal area. After the conversation we spoke with the visiting healthcare professional who had told us, they acknowledged it was confidential and sensitive discussion and it was inappropriate to have had the discussion in the room, but that the home did not offer a private area. We raised this with the registered manager who advised that they could have used the nurse's office but advised going forward; they would ensure a private area is offered to visiting healthcare professionals.

We also observed one person who requested help to go to the toilet. A staff member approached to remove a nearby wheelchair but did not speak with or acknowledge the person. We observed 20 minutes later the person began shouting, "Nurse, nurse, I'm wet through." At this point a staff member responded stating she would get someone to help. A further 30 minutes later, we saw that no staff had been to assist the person. They were heard saying to another person, "This pad is wet through. I told them but they took no notice." We then raised this with a member of staff in the room who said, "Yes I know, but I am on my own." Shortly after, another member of staff then entered the room and assisted the person from the lounge. This meant that people's dignity was not always maintained.

One person we spoke with told us, "I love reading, but I'm short-sighted and haven't had my glasses for a month so I can't read." We spoke with a member of staff who opened a drawer in the dining room and presented four pairs of glasses but none belonged to the person. When asked, the member of staff told us, "They belong to other residents." The member of staff then found the glasses which belonged to the person on a nearby book-shelf and provided these to the person. The person was seen still wearing these two hours later. As people hadn't been provided to the people who need them, they were not supported to maintain their vision. This meant staff had not ensured that people's needs were being met as they could not see properly and management had not monitored and corrected this issue.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw staff knock on people's doors before entering and only did so when invited. We saw one member of staff knock and say, "Hi [person's name], it's [staff's name], is it ok if I come in?" This meant that the person's privacy was maintained and respected.

People had mixed views about the support they received from staff. Most people we spoke with were complimentary about the support they received but some people commented that they felt staff did not have the time. For example one person told us, "They (staff) haven't got time to sit and talk, they're busy doing other things." Another person said, "The staff are alright, sometimes I have to wait, also some staff don't talk [to me], but some do." A relative said, "The staff are adequate in looking after mum. If I ask them to do things such as clean her nails, they will."

We observed that when staff interacted, they were generally warm, patient and kind with people and supported them in a caring way. They knelt beside people when supporting them and offered reassurance. We observed one staff member gently stroking a person's hand and speaking gently to them. However, we noted at times during our inspection visit that when staff walked passed people in the lounge, they offered no greeting or conversation.

People and relatives told us that they were involved in their care and support. We saw that people had signed their care plans where they were able to indicate that they agreed with what was planned.

Requires Improvement

Is the service responsive?

Our findings

People's social needs were not always met. Two people told us they were bored with not much to do. One person comment further and said, "We don't get to do many activities but on occasion we go to the park." They also commented they would like a pack of cards as it would give them something to do. People who chose not to participate in activities, their choice were respected. One person said, "Activities are not my cup of tea. I prefer my own company, I like to listen to music in my room or watch the TV, which I can do".

The provider employed two activities coordinators, one for each of the units. One activities coordinator was in post in the Sherwood unit and the other was due to start work in the near future in the Forest unit. On the day of our inspection visit the registered manager told us that the activities coordinator for Forest had been 'pulled out' to cover a shift in the kitchen at one of the provider's other homes. This meant that activities could not take place. We saw that the activities board was out of date and made reference to a coffee morning happening in August 2016. This meant that staff were not responsive to people's social needs.

People's needs were assessed before they began using the service and we saw evidence that the registered manager visited the people at home or in hospital. This was to ensure the service could meet people's needs. We saw that the pre-admission assessment formed the basis of the person's care plan. There was evidence that care plans were continually amended to reflect people's changing needs and reviewed on a regular basis.

Care plans we saw reflected people's likes, dislikes and preferences and showed that people and those close to them were involved in their own care planning. For example people's care record documented their preferred foods and activities. We saw that the provider wrote to relatives and invited them to take part in reviewing their relations care at regular intervals.

Care staff showed us a picture book they have created for one person who had difficulties communicating verbally. The book contained a series of familiar pictures that the person could point to whenever they wanted something. For example, we saw the person point to a picture of a cup of tea and staff were seen to provide this. This meant that staff were able to find alternative way to communicate with people and meet their needs.

People were encouraged and supported to develop and maintain relationships that were important to them. There were no restrictions on visiting hours and friends and relatives were made to feel welcomed. One relative said, "I used to ring up first before visiting, but not anymore, I can come when I like". We saw during lunch, that some family members were involved in supporting their relative to eat and drink as this is something that was important to the person.

People knew how to share and raise concerns and complaints. People we spoke with told us they felt comfortable raising any issues. We saw that the provider had a complaints policy and procedure in place. Complaints had been recorded and investigated and properly responded to. The policy also provided information on how people could escalate their concerns should they remain dissatisfied with the provider's

response. This meant that the provider had an effective complaints procedure in place.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection there was a breach of Regulation 17: Good Governance. This was because peoples care records were found to be incomplete in relation to the proper prevention of pressure sores and supporting people with diabetes. People's end of life wishes had not been clearly documented or reviewed. The provider sent us an action plan telling us what they will do to meet this regulation. We found some improvements had been made, however further improvements were still needed.

The provider had audit systems and processes in place to assess the quality of care they provide to people. The audits looked at variety of areas within the home such as fire, medication and care records. However these were not consistently or comprehensively completed. Where shortfalls had been identified they did not always record if action had been taken. For example, the registered manager's recent internal infection control audit identified an issue with overfull laundry baskets. There was no record to indicate what action the registered manager had taken to rectify the issue. We also saw that the regional manager had identified an issue with infection control within their audit, however their audit failed to specify what the issue was and action taken to ensure improvement is made. The registered manager told us that the issues had been discussed with staff and they were due to recomplete the audit to check if improvements had been made. However, there were no records of this discussion.

We found during this inspection that providers and registered managers' audits and checks were not effective in identifying whether or not people's care records were reflective of the care they received. For example, we saw that some people required their food and fluid to be monitored as they were at risk of malnutrition and dehydration. We observed drinks were being given throughout the day. However when we checked people's fluid charts, these had not been completed. We asked staff why these weren't completed and one member of staff told us, "We do not have time to do them." This meant that the fluid charts were not reflective of the person's intake. We discussed this with the registered manager who told us that staff should have recorded this information in their books which should have been transferred to the person's record during a quieter time during their shift and that she was going to discuss this with staff.

The audits and checks undertaken didn't identify whether staff were following advice from external health professionals and records were maintained. For example, we saw that a person was referred to Dietetics as they had been losing weight. The Dietician required the provider to ensure the person had high calorie and fortified food and to weigh the person weekly. We reviewed this person's records and found that over a 21 week period, the person had been weighed 11 times. This meant that the provider had not been following the instructions of external healthcare professionals and could delay further treatment should the person's weight change.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the end of this report.

The provider did not always notify us of issues and events that they are legally required to. When accidents and incidents occurred, these were documented by staff and reviewed by the registered manager. The

registered manager was aware of their responsibilities to notify external agencies, including us and the local authority but did not always do this. For example, an incident had happened within the home since our last inspection and these had not been reported to us. The provider and the registered managers also need to notify us when DoLS authorisations have been approved. We found during our inspection that some people had a DoLS in place for the use of bedrails but the registered manager had not informed us.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulation 2009. You can see what action we told the provider to take at the end of this report.

A relative we spoke with commented positively on the care that their relation received. They said, "The [registered] manager always calls me to let me know how my mum has got on at any appointments. If I have any problems or concerns, I have no problem discussing it with her as she is very nice and approachable." This told us that people felt comfortable discussing issues with the registered managers.

There were two registered managers in post and they had responsibility for the day to day running of the service. We observed the registered managers interacting with people and we saw that they both knew people well and engaged with them in an open way. People we spoke with felt the home was well run. One relative had said, "You can go to her with anything and she is really helpful." Staff commented that they felt the registered managers were supportive and always available should they need help or advice.

Handovers were held at the beginning of each shift. This procedure helped staff provide continuous and safe care. We saw in records that staff discussed each person's current condition, any healthcare needs and appointments, and any changes in their medicines. This enabled staff to have the most up to date information.

People who used the service were supported to have a say in how it was run through regular meetings and reviews of their care and support. Relatives were also supported to be involved via attending review meetings and by completing annual surveys. We saw that the registered managers wrote to people's relatives to invite them in to attend the review meetings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider and the registered managers did not notify us of events and issues they are legally required to. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulation 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and privacy were not always promoted or respected. This is a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always adequately protected from potential abuse. This is a breach of Regulation 13(2)(3)(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA RA Regulations 2014 Good governance

People's care records were not always reflective of the care they received. Audits used to monitor and assess the quality of the service were not effective in identifying issues and actions taken.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.