Encompass (Dorset)

Foresters

Inspection report

18-20 Alexandra Road
Weymouth
Dorset
DT4 7QQ

Tel: 01305777189
Website: www.drh-uk.org

Date of inspection visit:
25 February 2017

Date of publication:
31 March 2017

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service on 21 and 23 February 2016. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the deployment of staff.
We undertook a focussed inspection to check they had followed their plan and to confirm they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the "all reports" link for Foresters on our website at www.cqc.org.uk.
The inspection visit took place on 25 February 2017. Foresters is home to up to 15 people with learning disabilities in a residential area of Weymouth. At the time of our inspection there were 14 people living in the home.

The service had a registered manager at the time of our inspection. 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.

At this inspection we found that staff deployment had improved and cover was being sought with consideration of people's needs. There were support hours that were not being covered at the time of our inspection and this remained an area for improvement.

Agency staff had been used to cover hours in the home. The registered manger had not ensured that checks had been made on their suitability. We spoke with a senior member of staff who addressed this immediately and ensured the appropriate information was made available by the agency and checked before these staff worked in the home.

People were protected from harm because staff understand the risks they faced and how to support them to reduce these risks.

People were at a reduced risk because staff knew how to identify and report potential abuse appropriately.

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

We found that action had been taken to improve staffing deployment. However, we saw that some vacant hours had not been covered and there was a risk that a person had not been able to go out because of this.

Checks had not been made on some agency staff working in the home. This was rectified immediately.

People received their medicines as prescribed in ways that met their needs.

People were supported by staff who understood their role in keeping them safe. They understood the risks they faced and how to reduce these. They also understood how to identify signs of abuse and neglect and knew how to report these appropriately.

While improvements had been made we have not revised the rating of this key question as further improvement remained necessary.

We will review our rating for safe at the next comprehensive inspection.

Foresters

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 undertook an announced inspection of Foresters on 25 February 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our February 2016 inspection had been made. We inspected the service against one of the five key questions we ask about services: is the service safe? This is because the service was not meeting a legal requirement.
We announced the inspection because we wanted to be sure that there would be people in when we arrived. The inspection team was made up of one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. The provider had also completed a Provider Information Record (PIR). A PIR 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.

During our inspection we spoke with two people living in the home. Most of the people living in the home did not use words as their main communication method. Because people could not describe the care and support they received we observed the support they received from staff to help us understand their experience. We spoke with three members of staff. We also looked at records relating to 14 people's care, and reviewed records relating to the running of the service such as staff records and incident and accident records.

Requires Improvement

Is the service safe?

Our findings

At our inspection of Foresters on 21 and 22 February 2016 we found staff were not deployed in a way that met people's needs in the early mornings and at weekends. There was a breach of regulation.

At our focussed inspection on 25 February 2017 we found the provider had followed the action plan the provider had written to meet the shortfalls in relation to legal requirements.

Further improvements were required to ensure there were enough staff available to support people at all times. Staff told us that there had been an improvement and one person told us: "There are staff. I go out." They went on to describe trips out they had been on recently. People went out, or were offered the chance to go out, during our inspection. Rotas showed that the majority of hours were covered that were identified to meet people's day to day needs. However, in the month prior to the inspection staff were not available to support people with activities as planned on three of the four Saturdays.

We discussed the potential impact of these uncovered hours and reviewed activity records for these times. We found records indicated that people had not been able to go out frequently when these hours were uncovered. We were told that some activities may not have been recorded and the senior member of staff took immediate action to remind staff about the importance of recording.

The people who needed one to one cover had complex support needs and needed to be supported by people they were familiar with. This meant that it could be difficult to cover the hours but that this would improve when cover requirements diminished.

One of the ways that cover was provided was through the use of regular agency staff. We looked at records relating to these staff and found that the registered manager had not ensured that they had made checks on their suitability to work at Foresters. We spoke with a senior member of staff about this. They ensured that information was made available by the agency immediately to enable these checks to be made before the staff worked at Foresters again.

One person told us they felt safe and comfortable in Foresters and discussed what safe meant with us. Most people were not able to tell us about their experience because they did not use words as their main form of communication. We observed that these people were relaxed with staff; smiling and initiating interaction.

People were at a reduced risk of harm because staff were able to consistently describe the measures they took to keep people safe and this understanding reflected care plans that were written to mitigate assessed risks. For example staff described how they supported people to eat and drink safely and protected them from the risks associated with their epilepsy. During the inspection we observed care being delivered in ways that were described in people's care plans to reduce risk. For example, we observed two people being helped to eat in ways that speech and language guidance described. One of these people had recently had a change to their safe swallow plan and staff told us they had received a message about this and were up to date with the new plan.

Staff were confident they would notice indications of abuse and knew how they should report any concerns they had. Staff told us they had received information about how to whistle blow and were committed to doing so if it was needed.

Accidents and incidents were reviewed and actions taken to reduce the risks to people's safety. For example, one person had been identified at being at risk after an incident with their bed. Appropriate interim plans were put in place and liaison with health professionals had led to new equipment being provided to alleviate this risk. This meant that people were at a reduced risk of reoccurring accidents and they received support guided by the expertise of appropriate professionals.

People received their medicines and creams as prescribed and in ways that met their preferences. Medicines were stored and administered safely and we observed people receiving their medicines as prescribed and in the way their medicines care plan described. People were given information in ways that was meaningful to them and involved in all steps of the process. There was clear guidance in place about when medicines that were given when needed should be administered. This included pain relief and emergency epilepsy medicine. Some people were not able to communicate pain verbally and records detailed how staff would know if they were in pain using behaviour, facial and body expressions as indicators