SHC Rapkyns Group Limited

Forest Lodge

Inspection report

Horney Common
Nutley
Uckfield
East Sussex
TN22 4EA
Tel: 01825712514
Website: www.sussexhealthcare.org

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Ratings

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

Overall summary

This inspection took place on 3 and 9 November 2015. It was unannounced. There were 59 people living at Forest Lodge when we inspected. People cared for were mainly older people who needed nursing care and were living with dementia. People had a range of care and treatment needs, including stroke, heart conditions, breathing difficulties, diabetes and arthritis. Many people needed support with all of their personal care, eating and drinking and mobility needs. Some of the people were living with behaviours which may challenge others.

Forest Lodge is a large house which had been extended. People's bedrooms were provided over two floors, with a passenger lift in-between. There were sitting rooms and a dining room on the ground floor. Forest Lodge was situated in its own grounds, which were shared with other services, also owned by the provider. This group of services were situated in a rural area, north west of Uckfield in East Sussex. The provider for the service was SHC Rapkyns Group Limited, who own a range of services across south east England.

Summary of findings

Forest Lodge had a registered manager. 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.

Forest Lodge had been registered with the CQC for a period of time under a different provider, before this inspection. The home was registered by the current provider, SHC Rapkyns Group Limited, in November 2014, so this was the first inspection of the service since their new registration.

Some ways of ensuring the safety of people were not effective. This included the safety of people who used bed rails and people who may be at risk of trips and slips. There were systems to ensure the safety of people in other areas, including where people were at risk of falling, choking and had mobility needs.

People did not have care effectively planned and delivered for all areas of their care and treatment. This included where people showed high blood sugar levels, where people had small wounds and for some people who were at high risk of pressure damage. Care plans were in place for other areas, including where people may be at risk of low blood sugar levels, had large wounds and experienced behaviours which may challenge others.

Where people needed to be given their medicines in a disguised way (known as covert administration), there was a lack of care planning to ensure all registered nurses supported people consistently. Where people were given medicines 'as required' (PRN), care plans did not include relevant information known about by staff. There was also a lack of records to enable audit of covert administration of medicines and the effectiveness of PRN medicines for people. Other systems to ensure safe management of medicines were in place. All medicines were stored in a secure way and registered nurses appropriately supported people when giving them their medicines.

The provider's audits did not identify a range of relevant areas, including systems for ensuring the privacy and dignity of people where they shared double rooms, the cleanliness of certain pieces of equipment and ensuring all staff moved people in a safe way. Other systems were audited effectively by the provider, including fire safety and response times when people used their call bells.

People and their relatives said they felt safe in the home. Staff knew about how to ensure people were protected against risk of abuse. All staff were aware of their responsibilities where people lacked capacity. The manager had ensured relevant referrals were made to the local authority under the Deprivation of Liberty Safeguards (DoLS).

People and their relatives said staff were caring. They said the home's systems supported people's independence and promotion of choice. Staff ensured people's privacy and dignity in their day to day care and treatment.

People commented favourably on care and treatment provided at the end of people's lives, so that people's care at those times was person-centred and as pain-free as possible.

People said there were enough staff on duty to support them. Staff were available to respond quickly to people when they needed assistance. There were systems to ensure staff were recruited in an appropriate way. Staff were trained in their roles and regularly supervised to ensure they could provide effective care and treatment to people.

Where people needed support from external professionals, such as a dietician or speech and language therapist (SALT), the home ensured referrals took place promptly and professionals' directions followed.

People received the support they needed to enable them to eat and drink what they wanted. They could choose where they ate their meals. Staff were available to support people who needed assistance with their diet and fluid intake.

The home employed a range of activities staff. A range of activities were provided to people to suit their diverse needs. People were fully supported in participating in activities as they wished.

People said they could raise issues with managers when they needed to. They felt confident action would be taken

Summary of findings

if they did this. People and staff commented on the support they received from the registered manager and the senior managers for the provider. People said the home was well managed and supportive of their needs.

During the inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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.

All relevant guidelines to ensure the safety of people from risk were not being followed.

Effective systems were not in place for all areas in the management of medicines.

There were full systems to ensure people were protected from risk of abuse. Sufficient staff, who had been suitably recruited, were in post.

Is the service effective?

Good

The service was effective.

Staff were supported by training and supervision to ensure they provided people with the care and treatment they needed.

The home had full systems to ensure people were assessed in accordance with the Mental Capacity Act (2005) and relevant referrals were made where people were at risk of being deprived of their liberties.

The home liaised effectively with external professions where people needed additional support.

People could choose where they ate their meals. Where people needed it, they received the support they needed with eating and drinking.

Is the service caring?

Good

The service was caring.

People said staff cared for them in a kindly and supportive way.

Staff respected people, ensuring their individual needs were met and their privacy and dignity maintained.

Where people were at the end of their lives, care was provided in a person-centred way.

Is the service responsive?

Requires improvement

The service was not always responsive.

People people's care plans did not always reflect all their needs, to ensure staff met their care and treatment needs in a consistent way.

A wide range of activities were provided to meet people's recreational needs.

People could raise issues they were concerned about. They said they were responded to appropriately if they did this.

Summary of findings

Is the service well-led?

The service was not always well led.

The provider's systems for audit did not always identify some areas, to ensure effective service provision.

People commented favourably on the culture of the home, including the supportive and approachable style of the registered manager and senior managers working for the provider.

Requires improvement

Forest Lodge

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 3 and 9 November 2015. It was unannounced. The inspection was undertaken by one inspector.

Before our inspection we reviewed the information we held about the home. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with 15 people who lived at Forest Lodge and observed their care, including the lunchtime meal, medicines administration and activities. As some people had difficulties in communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people's relatives and visitors. We inspected the home, including people's bedrooms, sitting rooms, the dining room and bathrooms. We spoke with 14 of the staff, including registered nurses, care workers, domestic workers, activities workers and the chef. We met with the registered manager and two managers for the provider. We also spoke with visiting external healthcare professionals.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

People commented positively on safety in the home. One person told us "Oh yes, I feel safe here." A person's relative told us there was "Absolutely no question," about their relative being safe at the home. Another relative told us their relative could show behaviours which may challenge others. They said when this happened "I know they're in safe hands." People also said one of the reasons they felt safe was because of the staffing levels. One person said there were "Always enough staff." A person's relative told us their relative needed frequent support. They said "I've never had a problem about staffing or getting staff."

Although people felt they were safe at the home, we found the safety of people had not been ensured in some areas. A person was lying in bed during the afternoon of our first day of inspection. One of their legs was over their bed rail and they were lying in their bed in a way which put them at risk of coming over the top of the bedrail. Although there was floor protection, they could have sustained an of injury if they fell from such a height. We asked staff to come and ensure the person's safety, which they did. We asked a member of staff about what we observed. They reported this was not the only occasion when the person had been found to have been at such a risk. We looked at the person's records on the second day of the inspection. We saw no records had been made of what had happened and there were no records of similar observations as reported by the member of staff. When we visited a different person during the afternoon of the inspection, we saw they had their leg trapped between their mattress and bed rail. When we called a member of staff, they found the person was unable to move their leg without active assistance from staff to do so. On the second day of the inspection, no record had been made of what had happened.

The Health and Safety Executive (HSE) has clear guidelines on the risks associated with the use of bed rails. The guidelines emphasise the importance of risk assessments when bed rails are used, particularly where people may show restless behaviours. They also outline the importance of recording of any relevant issues, to support risk assessment and care planning. Neither of the people we met with had a risk assessment about the use of bed rails for them. We asked staff if they had received training on the safe use of bed rails. None of the staff we spoke with had been trained in the area and they were not aware of HSE guidelines.

The HSE also advise risk, particularly of slips and falls, to people need to be assessed and relevant actions taken to reduce risk. We went into the room of a person who staff told us used their basin in the room to wash in. The space between the end of their bed and the basin was narrow, at approximately 50 centimetres. The area was also dark. The person's records did not include any assessment of how risk to them was to be reduced from using a basin in a confined space in a dark area of their room.

The home were not always ensuring risk to people was assessed and relevant actions taken to mitigate such risks. This is a breach of Regulation 12 of the HSCA Regulations 2014.

However, in other areas assessments of risk for people had been completed to ensure risks were reduced as much as possible. All people were regularly assessed for risks relating to mobility, falling and pressure ulceration. If a person's risk changed, their assessment was promptly reviewed. For example staff told us about a person whose mobility needs had recently changed. Their pressure ulceration risk had been reviewed and the member of staff who led on safe moving and handling was in the process of reviewing their moving and handling risk assessment.

We met with a person who was chewing on a blanket. Staff told us the person tended to put small items into their mouth and was at risk of choking because they did this. They made sure the person did not have items to hand which could put them at risk. The person had a clear individual risk assessment and care plan about this risk. These had been regularly reviewed to ensure the person's risk from choking on small objects was reduced as much as possible.

All of the people needed support with taking their medicines. Several people needed to be given their medicines in a disguised way (known as covert administration). We spoke with registered nurses about how they gave people their medicines in this way. They described what they did. For example a registered nurse told us they gave a person their medicines hidden in yogurt. None of the ways people were given their medicines covertly were documented, to ensure all staff,

Is the service safe?

including agency staff, would be aware of the person's individual plan for taking their medicines in this way. There can be a risk that some medicines may be affected by how they are administered. The home had not consulted a pharmacist to ensure the medicine remained effective when given in the way they were giving it to people. People's medicines administration records (MAR) did not document the occasions when the person had needed to be given their medicine covertly. This meant an audit could not be performed of how often and the reasons why the person had needed to be given their medicine in this way.

Some people were also given medicines, such as painkillers and mood altering medicines, on an 'as required' (PRN) basis. Each person had a protocol about when they should be given such medicines. These protocols were brief and stated only such information as that the medicine was 'for agitation' or 'when in pain,' with no further detail. However, when we spoke with registered nurses they gave us clear descriptions of how each person showed symptoms of anxiety or pain. These were not documented to ensure all other staff who supported the person had access to such information. One of the people who was prescribed a painkiller had a pain scale record. This had not been completed, although they had been given the medicine and their care plan said the pain scale should be completed. Another person was prescribed a mood altering medicine which had been given to them three times in November 2015. They did not have a record of their symptoms to show the extent of their anxious behaviour and the degree to which it was affecting them. Neither person had any record to enable assessment of the effectiveness of the medicine after they had taken it. This meant such information was not available to inform registered nurses and other relevant professionals of the effect or otherwise for the person.

The home were not always ensuring the proper and safe management of medicines. This is a breach of Regulation 12 of the HSCA Regulations 2014.

However the home were ensuring the safe and proper management of medicines in other areas. We saw medicines were given to people in a safe way. Registered nurses made sure medicine trolleys were always locked when they were not with them. They gave each person the time they needed to take their medicine, giving them appropriate support, including reminding them of what their medicines was for. Registered nurses did not sign the MAR until they had seen the person had taken all of their medicines. Medicines were stored securely and in an ordered way. All limited life medicines were dated on opening, to ensure they were not used after they had expired. The home's GP said the home effectively planned their ordering of medicines so people did not run out of the medicines they needed. Where people needed medicines to be administered by injection, full records were maintained of injection sites, to ensure such persons were not at risk of tissue damage from over-use of the same injection site.

People were safeguarded from risk of abuse. One person's relative said one of the people could at times stand and stare at other people who were living in the home. This could be alarming for their relative and themselves. They said staff always noticed this and would attend the person in the way they needed, so both they and their relative felt safe. Another person's relative said their relative needed close observation because of their behaviours which may challenge. They said the person was "Never on their own."

All of the staff we spoke with were aware of their responsibilities for safeguarding people from risk of abuse. This included ancillary staff like the laundry worker. Several of the staff told us they needed to observe people closely for changes in their demeanour. This was because changes in people from how they normally were might indicate a risk of abuse. One care worker told us they had reported such a change in a person to their manager in the past.

We looked at staff files to review if people were recruited in a safe way. Files included relevant records for the recruitment of staff, including checks with the criminal records bureau and two satisfactory references. Where staff were recruited whose first language was not English, files showed certificates of assessments in competence in English language. Some interview assessment records were very brief and some staff files were complex to audit because records were not kept in an ordered way. The registered manager said, as many of the staff had remained in post for an extended period, they had been recruited before she came into post. Now she had addressed other areas in care delivery in the home, she had plans for a full review of all staff files.

The staff rota showed the service were using some agency workers. A GP commented on how much the situation had improved, saying high levels of agency staff were used in the past but "Now there are very few." The registered

Requires improvement

Is the service safe?

manager said they had been successful in working with the agency to ensure the same agency staff were sent to the home, to ensure agency workers knew people and the home's systems.

People generally said there were enough staff on duty to meet people's needs. A person's relative said they were pleased with the way there were always staff available in the sitting room and dining room. One person's relative who said their relative needed frequent observation, said they had "Never had a problem, staff are always there."

Another person said when their relative remained upstairs, staff were "Always coming round" to check on the person's safety. A member of staff told us staffing levels were "Usually very good." We observed there was always one and usually several, members of staff available to support people in the sitting rooms. Staff were also prompt in responding when people needed assistance. When we rang to summon assistance for a person, staff responded to the call bell in under two minutes.

Good

Is the service effective?

Our findings

People said they felt the service was effective because staff were fully trained. One person's relative said "Oh yes staff are all trained here." Another person's relative said staff were "Well trained in dementia." Another person's relative said because of their training staff knew how to support their relative in a safe way when they showed behaviours which may challenge others. A person's relative said their relative was living with epilepsy as well as dementia. They said because of their training staff managed the person's epilepsy "Well, they know what to do." A GP described staff as "Competent."

Staff said the training provided by the provider supported them in their role. A member of staff said "We've a lot of training." Another member of staff told us the training programme provided "Lots of things relevant to my job." A different member of staff said the training programme "Offers opportunities" for them to develop in their role. A newly registered nurse described how much they had been supported by their induction programme when they started. They said there was always someone they could go to if they felt they needed support or advice. All members of staff commented positively about their dementia training. One member of staff described the dementia training as "Effective."

A member of staff said the supervision system helped them to develop in their role. They said they had told their supervisor they thought they needed more training in supporting people who were living with diabetes. Due to this, they were now mid-way through a training programme in diabetic care and treatment. Day to day supervision was effective in practice. At lunchtime, we saw a care worker was standing up to support a person to eat their meal. This was promptly observed by a senior care worker who quietly advised the care worker on how to appropriately support a person who needed assistance to eat. The care worker went and got a chair after this intervention, so they could support the person in a more appropriate way.

The registered manager maintained a training matrix so they could see at a glance who needed training and who was due training, so any issues could be followed up on. The manager also had a supervision matrix to ensure staff received the support they needed in their role. When we looked at supervision records, they were individually completed with opportunities for staff and their supervisor to raise issues. Senior staff said if they observed a more junior member of staff who was not working in accordance with the home's policies and procedures, they advised the member of staff of how they were expected to perform. They would also tell the registered manager, so if the person needed additional support in their role, this could be provided. There were fully completed records of induction programmes for staff, including induction for agency workers.

All of the staff we spoke with were fully aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Staff discussed with us the importance of best interests meetings where people lacked capacity. A GP said they were involved in such meetings and they took place where relevant to ensure people's well-being. Staff could also identify people who might be at risk of being deprived of their liberties and about how the home safeguarded them. Records showed the registered manager had ensured relevant referrals were made under DoLS for all people, where relevant.

People's relatives said the home ensured people were referred promptly for support from external healthcare professionals. One person's relative said their relative had been referred to the dentist for new dentures when their old dentures stopped fitting. Another relative said the home had worked with the community psychiatric nurse to support the person, who had behaviours which may challenge others.

People said the home managed emergencies in an efficient way. One person's relative told us they had been in the sitting room when a person had collapsed and fallen to the floor. They said staff got support "In seconds." Staff who supported the person reacted to the emergency "So calmly" that none of the other people in the area were made anxious by what had happened. The activities worker told us if they needed to ring the emergency bell, staff were always "Prompt at coming," to ensure the person's well-being. A GP said the home was effectively organised. This meant people were supported if they were unwell, to prevent admissions to hospital as much as possible. They said this was effective for people because many of them, due to living with dementia, found hospitals an alarming place to be.

Good

Is the service effective?

People were positive about the meals. A person described the meals as "Fine," another as "Great" and another as "Always good." A person's relative told us "The food always looks very nice" and "The cakes are good."

We observed a mealtime. There were plenty of staff available to support people where they needed assistance. In the dining room we saw a couple of people who lost concentration when eating their meal. This was promptly observed by staff who gently reminded people of where they were and that their food might be getting cold. Where people needed full support from a member of staff to eat, staff sat with them, they supported them in an unhurried way, ensuring they had safely swallowed each mouthful before they were given more to eat.

People could choose if they ate in the dining room, remained in the sitting room or ate in their own room. The chef told us about the importance of being flexible to ensure people ate what they wanted, where they wanted. Meals were served in an orderly way. This ensured people received their chosen meals. Where people changed their mind about what they wanted to eat, their decision was respected. One person said they did not want either choice and asked for a glass of milk. This was given to them. The chef had full written information on people's allergies, likes and preferences.

Some of the people were at risk of weight loss. A person's records showed they were losing weight. The person had been promptly referred to a dietician when this happened and their care plan revised to reflect the dietician's advice. Many people needed thickening agents in their drinks to enable them to swallow safely. One person's records showed they had been referred to a speech and language therapist (SALT) for a swallowing assessment. Their records showed they had been referred back for further advice when their condition changed. The person's care plan was clear, documenting the SALT's advice on the consistency they needed to have their drink, to enable them to swallow safely. Throughout the inspection, the person was always given their drinks at the consistency advised by the SALT.

Where people needed support with taking in adequate fluids to prevent risk of dehydration, their fluid intake was monitored. Records were not completed until after people had drunk what they wanted to drink. This meant charts were an accurate record of what a person had drunk. All fluid charts were totalled every 25 hours. This enabled review of people's daily fluid intake and meant staff could take action if people were not drinking sufficient amounts.

Good

Is the service caring?

Our findings

People said the home was caring. One person said "I'm quite satisfied with the care." A different person said "They're all my good friends," about the staff. A person's relative said staff were "So respectful." A different person's relative told us "Love, care and respect, that's how the home is run." A person's relative commented "What I really like is how all the staff know all of their names and use them to speak to them."

A person's relative told us they appreciated the way people were cared for in the home. They said their relative always looked "Smart" and their clothes were "Colour coordinated." They said this showed staff respect for how people wanted to be dressed. A different person's relative told us if a person dropped food or drink on their clothing, staff noticed and took prompt action to ensure the person was supported. A person's relative said they were impressed by the way staff noticed smaller matters, like a support cushion no longer being placed in the right way for a person, and took action to make the person comfortable again.

When people sought assistance from staff, they responded quickly. One person called out in a worried tone when they were in the sitting room, apparently because they had forgotten where they were. A member of staff responded to them promptly to support them and remind them of where they were and what was happening. Staff were consistently polite to people. A member of staff was moving a wheelchair in an area of the sitting room. To do this they needed to move a table which was next to a person. They asked the person's permission to do this, explaining they would put the table back as soon as they had gone past with the wheelchair, which they did. In the period after lunch when people were gradually being assisted back into the sitting room, one member of staff was allocated to support people in the sitting room. The member of staff was not intrusive but they were clearly ready to support any person who needed assistance, so people could have their needs met at that time and did not become distressed or worry other people.

The home's systems respected people and ensured their individual needs were met in a dignified way. We met with a person sitting in their room. From the appearance of their room it looked as if they liked to eat biscuits independently and there were a number of crumbs on them and the floor around their chair. When we returned after coffee time, all of the crumbs and the dropped biscuits on the floor had been removed. We met with a person who was confused about time and place. They were relaxed and comfortable, showing no signs of distress. A member of staff told us the person became anxious in the sitting room and were more comfortable in their own room, and they respected this, to ensure the person remained calm and unworried.

Several of the people had difficulties with their continence. The home managed such needs discretely to ensure people's privacy and dignity was maintained. A person told a member of staff they needed to go to the toilet, at a very busy time. The member of staff said "Of course" and promptly took the person to the toilet. A member of staff assisted a person to stand up. On standing the person up, they observed the person's cushion protector was wet. They quietly asked another member of staff to take the protector away and change it, while they assisted the person. All this was done quietly and discretely so as not to concern the person or others in the vicinity. We went into a communally used toilet in the mid-morning. It had been recently used and was contaminated and needed cleaning. When we returned to the toilet later on, it had been fully cleaned and all debris removed. The toilet smelt fresh.

Staff supported people in choosing and being as independent as possible. A member of staff asked a person if they wanted to go to the dining room for lunch. The person was not able to retain all of the information. The member of staff gently explained to the person that if they wanted to go to the dining room for lunch, they would need to walk with them, or if they preferred, they could eat their lunch in the sitting room. They made sure the person understood the choice and waited while the person made their decision, respecting their choice. After lunch a person was unsure of what to do. A member of staff reassured them, asking them where they wanted to sit and giving them choices such as sitting in the conservatory, sitting by a window or closer to the television. A member of staff supported a person to move using a hoist. They explained why they needed to do this and sought the person's permission to use the hoist for them. They reminded the person throughout the time they were helping them about what they were doing and why.

The home provided end of life care, including for people who were living with dementia. One of the people we met with was receiving such care. They had a room close to the

Good

Is the service caring?

nurse's office. Records showed staff visited them at least every quarter of an hour to check on how they were. The person looked comfortable, with nicely brushed hair and clean night clothes and bedding. Staff knew about this person's needs. What staff told us was reflected in the person's care plan. A relative told us about their relative who was also receiving end of life care. They said they were as involved with supporting the person as much as they wanted to be. They said staff understood their own needs too. They said this meant they felt "Confident" not to sit with the person when they felt they needed to go home and rest. They said the home were "Very prompt" in letting them know about any changes in their relative's condition. A GP said the home were efficient at ensuring people had adequate stocks of pain relief for people, so they did not run out at weekends and bank holidays. They said staff knew each person "Very well. " This enabled the home to ensure "A good death" for people.

Requires improvement

Is the service responsive?

Our findings

People said the service was responsive to their needs and they were consulted about their care. One person's relative said "I couldn't ask for [their spouse] to be better looked after." A person's relative described their relative's behaviours which may challenge and said staff always responded well when they showed such behaviours. A person's relative said they felt "Very involved" with developing their relative's care plan. A different person said they appreciated the way staff always consulted them about changes, describing a time when the person had shown restless behaviours, including wandering about the home at night. They described how the staff had discussed with them the different ways they were planning to support their relative, to ensure their safety. A relative said "I can come in when I like – it's very nice."

The home was not consistently ensuring they responded to all of people's needs. One person spent most of their day sitting in a chair beside their bed. They were not able to move independently. The person was assessed as being at high risk of pressure damage. The person's records showed they could be sitting out of bed without support to change their position for a period as long as eight hours. People's risk of pressure damage does not reduce when they are sitting out of bed. The person's care plan also did not state how the person's risk was to be reduced when they were sitting out of bed. When we asked staff about this they told us about differing ways they supported the person to reduce their risk when sitting out of bed. The National Institute for Health and Care Excellence (NICE) guidelines on prevention of pressure damage state that pressure wounds, once developed take an extended period to heal, can be painful and may be a source of infection, therefore the emphasis must always be on their prevention before they occur. The home had not followed these guidelines for this person.

A person was living with diabetes, their records showed they had experienced two occasions recently when they had shown high blood sugar levels. High blood sugar levels can affect how a person feels and can also affect their general condition. The registered nurse knew about the reasons for one of the occasions where the person had experienced a high blood sugar level. This was not documented in the person's records to inform other staff. The registered nurse did not know what had happened when the person had the other high blood sugar level. The person did not have a care plan about actions staff were to take when the person's blood sugar level was high, such as checking the reading again, when to inform the person's GP and what actions staff were to take to support the person during the period when they had raised blood sugar levels.

Two of the people had small dressings visible on their arms. Neither person had a plan of care about the wounds and how they were to be treated and observed until they healed. No on-going records had been made about the condition of the wound, although one person had clearly had the dressing changed between the first and second day of the inspection. Smaller wounds, particularly in older people who were living with a range of other medical conditions, can deteriorate or become infected, however full information was not available to advise staff on how people was to be supported with such wounds until they were healed.

The home were not always ensuring risk to people from pressure ulceration, diabetes and wounds was mitigated to ensure people received safe care and treatment. This is a breach of Regulation 12 of the HSCA Regulations 2014.

The home was ensuring people's needs were responded to in other areas. Where people were living with diabetes, they had clear care plans about the risk of low blood sugar levels to them and actions to be taken to support the person should this happen. Staff we spoke with knew about these plans. Where people had large wounds, there were clear care plans and the progress of the wound to the treatment programmes was regularly assessed and reviewed. People had clear care plans about how they were to be supported in their dementia care needs. Staff knew about people's individual needs. This included one person where staff told us they left them on their own for a short period of time, if they showed symptoms of anger, so the person's angry behaviours did not escalate. A different person had a care plan about the risk to themselves from having a call bell. Their care plan set out how their safety was to be ensured as they did not have a call bell. This care plan had been regularly reviewed with the person's relative.

People made positive comments about activities. One person smiled at us and said "We do a lot of singing, I like singing." A relative said "There's always lots of activities

Requires improvement

Is the service responsive?

going on. ” A different person’s relative said “The entertainment here is such fun.” A person said how much they appreciated being helped to go outside, telling us “It’s so nice when they take you for walks around.”

Throughout both days of the inspection, activities and entertainment were provided for people. These took the form of larger or smaller groups. For example on the first day of the inspection a volunteer was running a small knitting circle which the people involved were clearly enjoying. A person told us they enjoyed the way the home had arranged for a person to come regularly and play cards with them. Larger group activities were provided in the lounge. Sometimes these were provided by external entertainers, others by the staff. For example on one day there was a quiz involving theme tunes from famous television programmes. The activities workers were supporting people in being involved in the quiz. There was much laughing, joking and singing throughout the activity. On another occasion music was being played and one of the care workers was helping a person to be involved by dancing with them, holding their hands, while they sat in their chair. The person was laughing and smiling. Some people remained in their rooms all the time. The activities workers visited these people for 1:1 support. They kept records of how they had supported the person and their response to this support.

The home employed several activities workers, they were supported by volunteers. This meant activities were available seven days a week. It also meant there were enough activities workers to give people the support they needed with engagement. Additionally care workers and registered nurses were available to support people during activities, so people who needed it could have any additional support they needed with engagement.

People said they could raise concerns or complaints if they needed to. The complaints procedure was displayed in the reception area. A person said “Yes I’d tell the manager if I was worried.” A person’s relative said there were “Always senior staff to talk to” if they needed. One relative said they had mentioned an issue of concern about a particular member of staff to a senior member of staff, and it had been “Dealt with at once.” A different relative said they had brought up a slight concern about a tree in front of their relative’s window, which had grown so it was beginning to stop the light from coming into their relative’s room. The said it had been “Sorted” by the next time they visited.

Regular residents meetings were held. The minutes of the last meeting showed the chef had been present. Comments had been made to the chef about the meals, which they had responded to. Relatives meetings were also held. A person’s relative told us these took place “Regularly” and that they “Can voice any issues during the meeting.” We looked at the results from a recent survey of relatives about the quality of care. All responses from relatives were positive about the standards of care provided by the home.

Requires improvement

Is the service well-led?

Our findings

People gave us positive comments about the home. One person said "I find it a very nice place" and another "I'm very happy here." A person's relative said "The quality is next to none" and another described the home as "Very welcoming." A person's relative said they could talk to the registered manager "Anytime" and another that the registered manager "Cares for everyone." A GP said the registered manager "Leads by example."

The provider had established systems for reviewing the quality of care provided. Some of these required improvement because they did not always identify relevant matters. Some of the people were cared for in double rooms. The home's statement of purpose and mission statement did not advise people about the double rooms, including how people were to make choices about being accommodated in a double room and how people's privacy and dignity was to be maintained when they shared a room with a person they had not known previously. A person had put a lock and chain on their wardrobe in the room they shared. A care worker told us this was because they wanted to keep their own personal items private. This was not documented in their care plan. The home's quality audits had not identified that people's care plans did not take factors such as the effect of sharing a room into account when considering quality of care for people.

Infection control audits considered a wide range of areas but did not include areas such as review of systems for the cleaning and maintenance of equipment such as wheeled commode chairs. All of the commode chairs we looked at showed rust on their chassis. As audits had not identified such matters the provider had not ensured the wheeled commode chairs were kept visibly clean, free of rust and any risk of cross infection reduced. Accident audits did not consider factors like time of day when the accident occurred to assess if time of day was a factor in when accidents occurred. Accident audits did consider other factors such as the number of unwitnessed falls.

Some other areas had not been identified by the provider's audit processes, however the provider did take prompt action to address them when they were identified. On the first day of the inspection. We observed two occasions when staff assisted people to move in an unsafe way by lifting people under their arms, which could have put the person's shoulder joints at risk of injury. We informed the provider of what we had seen and the provider took action by ensuring their trainer provided immediate re-training to all staff. On the first day of our inspection there were receptacles in the laundry of un-named, used, net underwear, 'pop socks' and men's' dark socks. All staff we asked about these items reported they were used communally for people when needed. The provider took prompt action after our first day of inspection and removed all such items from the home, to prevent communal use of underclothing.

The provider's systems did identify a wide range of other areas. These included reviewing if staff responded promptly when people rang their care bells. Audits included review that people who remained in their rooms had drinks and call bells to hand, where needed.

Where the provider identified issues in their own audits, they took action. For example in a recent audit they identified that the external clinical waste bins were not always locked. They had rectified this and ensured clinical waste bins were always secured, to prevent risk of vermin accessing the bins and leading to a risk of contamination of the local environment. The provider's audits also noted and ensured action took place in smaller areas, such as the replacement of bedside light bulbs.

There were systems to ensure the health and safety of people, including checks that water temperatures were safe, and fire safety checks and audits. All files were maintained in a clear and orderly way, to show the current situation and any areas which needed attention. Following a recent review by the local authority quality monitoring department, all people's personal emergency evacuation plans were being revised, to ensure they reflected people's individual needs.

The provider had identified areas to improve the quality of care for people who were living with dementia. In one corridor, all people's bedroom doors had different facias on them, which gave the doors the appearance of being house front doors. Staff said this helped people identify their own rooms and enhanced people's privacy and dignity, as people were less likely to go into rooms which looked private. One of the smaller sitting rooms had been wall-papered so it looked like a library, which distinguished it from other sitting rooms and enhanced the quiet, restful atmosphere of the room. The area manager said they were looking to extend such developments in the near future.

Requires improvement

Is the service well-led?

Staff commented favourably on the culture of the home. One member of staff said with "Any problem, they are approachable, even the area manager." Another member of staff said the company had always been "Supportive" to them. A member of staff said the home was "A nice place to work" and another said "It's like a family here." A registered nurse said if they had issues they could discuss them with the registered manager, they listened and took action. A volunteer described the home as "Wonderful, one of the best."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not ensuring care and treatment was provided in a safe way for people because they were not assessing all relevant risks to the health and safety of people and doing all that was reasonably practicable to mitigate any such risks. They were also not consistently ensuring proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)