SHC Rapkyns Group Limited

Forest Lodge

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

About the service:
Forest Lodge is a residential care home that provides personal and nursing care to people aged 65 and over and people living with dementia. At the time of the inspection 49 people were using the service. Care and support was provided in one adapted building. The building had three units providing care to people: Beech, Ash and Cedar Unit.

Forest Lodge is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns previously raised, the provider is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found:
People and their relatives spoke highly of the service. Comments included, "I am as happy as I can be here, yes I feel safe as everything is made to make you feel safe here," and "Perfectly safe here, I watch and listen and formulate, I have never seen anything to worry me or I would be doing something about it." Risks associated with people's care were not however, consistently safe. Where people displayed behaviours which challenged, robust guidelines and risk assessments were not always in place. The risks around restrictive practice were not regularly reviewed and documentation to monitor people's behaviour were not accurately completed.

Quality assurance frameworks were in place; these were not consistently effective in driving improvement or identifying shortfalls. Forest Lodge has been in continuous breach of regulations since May 2018 and internal quality assurance frameworks have failed to drive and sustain improvements. Accurate documentation was not consistently maintained. Links and engagement with the local community required strengthening.

People were not always supported to have maximum choice and control of their lives. The application of the Mental Capacity 2005 was inconsistent and people's capacity to consent to specific decisions had not always been assessed. The provision of activities required further development. Activities were not consistently meaningful or tailored to people's needs. The care planning process required further development to ensure people's social and emotional needs were understood and met. The risks associated with social isolation had not always been assessed or mitigated. We have made a recommendation for improvement. Further work was required to ensure information about people's care and treatment was always made available in the most accessible way.

Staff felt supported and had access to a range of training. People's nutritional needs were met, and people spoke highly of the food provided. Risks associated with catheter care, skin integrity and dehydration were managed well. People had ongoing access to healthcare professionals and staff recognised and responded well to signs that a person's health might be deteriorating. Advanced decision care plans were in place and

the registered manager was working with staff, people and relatives to make these care plans more personalised.

People told us they felt safe living at Forest Lodge. Relatives also confirmed that they felt confident leaving their loved one in the hands of staff. Systems were in place to determine staffing levels and safe recruitment practices were operated. People told us that staff responded promptly to their care needs. People and staff spoke highly of the registered manager and the registered manager was compassionate about ensuring people received high quality care

The provider employed a team of dedicated housekeepers. Staff had access to personal protective equipment (PPE) and the service presented as clean and tidy. People and their relatives told us staff were kind and caring, listened to them and respected their choices. People were encouraged to be involved in their day to day care and be as independent as possible. Staff recognised the importance of meeting people's emotional needs and made visitors feel welcome.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
We last inspected Forest Lodge on 8 and 9 May 2019. The report was published in July 2019 and then re-published to include information about enforcement action on 23 October 2019. The service was rated Inadequate. The provider was found to be in breach of Regulation 12 – Safe Care and Treatment, Regulation 13 – Safeguarding Service Users from Improper Abuse or Treatment, Regulation 9 – Person Centred Care, Regulation 15 – Premises and Equipment. Regulation 11 – Need for Consent, Regulation 18 – Staffing and Regulation 17 – Good Governance. Enforcement action was taken. At this inspection, some improvements had been made but the provider remained in breach of four regulations.

This service has been in Special Measures since May 2019. During this inspection the provider demonstrated that some improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures

Why we inspected:
This was a planned inspection based on the previous rating. You can see what action we have asked the provider to take at the end of this full report.

Enforcement:
We have identified four breaches of regulation in relation to mental capacity, safe care and treatment, safeguarding and good governance.

We had previously imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Following the last inspection in May 2019, we imposed conditions on the provider's registration which required them to submit a monthly report regarding the management of activities, falls, moving and handling, medicine management, infection control and behaviours which challenge at Forest Lodge. We will continue to use this information to help us review and monitor the delivery of care at Forest Lodge.

Follow up:
We will request an action plan from the provider to understand what they will do to improve the standards of quality. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority and care commissioners to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always Effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always Caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always Well-Led.

Details are in our Well-Led findings below.

Forest Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection took place over two days. The inspection team on the first day consisted of two inspectors, a specialist nurse advisor 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. On the second day, the inspection team consisted of two inspectors and a specialist nurse advisor.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection in May 2019. This included details about incidents the provider had notified us about, such as allegations of abuse. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and nine visiting relatives about their experience of the care provided. We spoke with two visiting healthcare professionals; the registered manager, deputy manager, operations director, two activity staff, four registered nurses, the administrator and five care staff. We observed the delivery of care in communal lounges and dining rooms. 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 reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Further information was sent to the inspection team via email after the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. This was because people were not protected from the risks of inappropriate restraint. Medicines were not managed safely, and risks associated with people's care were also not managed safely. The provider had also failed to ensure adequate cleaning took place to combat odours caused by incontinence. At this inspection this key question has improved to Requires Improvement. However, ongoing work was required to safely manage risks associated with people's behaviour which challenged. This meant some aspects of the service were not always safe and there was limited assurance about peoples' safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse:

- At the last inspection in May 2019, the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people were not protected from the risks of inappropriate restraint. One person's behaviour care plan identified they may become physically aggressive towards other service users and staff. Their plan contained directions that it may be necessary for up the three staff to physically hold the person's shoulder and hands and re-direct the person if this happened. Staff had not received training to safely manage behaviours that may challenge including safe physical re-direction or restraint techniques. There was no reference or specific direction in the person's care plan about how to hold and re-direct the person as safely as possible.
- At this inspection, care plans and risks assessments had been updated. The registered manager also confirmed that staff had received training on behaviours which challenged. They advised that this training covered topics such as understanding the positive support behaviour model, explaining the use of reactive and proactive strategies and identifying the importance of reviewing and revising approaches to promoting positive behaviour. However, the training did not cover topics such as the use of safe physical re-direction.
- Staff confirmed that where people displayed physical aggression, they continued to use distraction techniques and physical re-direction, such as removing the person's hand or preventing the person from grabbing another person or staff member. Whilst staff confirmed that they had received training on challenging behaviour, staff advised that the training course was not an accredited course on the safe use of physical re-direction. This posed a risk that how one staff member might use physical re-direction would differ to how another staff member would use physical re-direction.
- Guidance was not in place on how to safely re-direct the person. For example, one person's challenging behaviour care plan identified for staff to leave the person alone. No guidance was in place on how to do this safely when the person was funded for 24 hours one to one support. Information on the actions to keep the person and other people safe in the event of their behaviours escalating to physical aggression lacked clear guidance and detail. One staff member told us, "(Person) will want to grab hold of your arm and try and squeeze it. If they grab onto my hand, I will try and relax them, try and distract them and get them a toy so will not hold onto me for long. They can get angry and grab people too. In those situations, I calm them down and talk to them, distract them with something else." Whilst staff confirmed that they had received training and found distraction techniques worked, the lack of guidance on the steps to take in the event of

the person's behaviours escalating increased the risk of the person receiving inappropriate support. The lack of guidance also posed the risk that staff's intervention would differ and that the person would not receive consistent support.
● One person's challenging behaviour care plan identified for staff to separate or isolate the person as a reactive measure (the use of separation or isolating a person is known as a restrictive practice). Information on how to do this safely was not documented within the care plan. One staff member told us that records of how long the person would be separated for or isolated would not be kept alongside how often staff checked on them. Whilst staff advised that the action of separating the person was not carried out regularly, poor recording keeping meant staff and the registered manager could not be certain. This meant the registered manager and provider were unable to review and analyse restrictive interventions and were unable to monitor how often the person received periods of segregation. This increased the risk of abusive practice.

The failure to safeguard people from abuse and improper treatment was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Despite the concerns above, people told us they felt safe living at Forest Lodge. One person told us, "I am as happy as I can be here, yes I feel safe as everything is made to make you feel safe here." One relative told us, "I know they are safe here. They wouldn't be here otherwise."
● Staff had received safeguarding training. This training was designed to aid staff understanding of signs of abuse, including discriminatory abuse, what these signs might look like and why it was important staff acted if they recognised any concerns. One staff member told us, "Safeguarding could be physical, emotional or sexual abuse. Any concerns I would report them to the manager straight away."

Assessing risk, safety monitoring and management:
● At the last inspection in May 2019, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because challenging behaviour risk assessments and care plans were not always consistent or contained enough detail. Actions for staff to follow that had been identified in these documents had not always been considered in line with best practice guidance. At this inspection improvements had not been made.
● Where people displayed verbal or physical aggression, challenging behaviour care plans were in place. However, these lacked details. Guidance produced by the Alzheimer's Society advised that for people living with dementia, the display of challenging behaviour can often be a sign of communication or the person trying to express a feeling and care staff should monitor for specific triggers. Care plans lacked information on specific triggers or how these behaviours presented and how staff should respond in a consistent manner. Staff told us that they found distraction techniques and providing people with space worked well. The lack of detailed information meant there was an increased risk staff were not responding appropriately or consistently. The service was using agency staff and the lack of detailed guidance increased the risk of agency staff not knowing how to respond in a consistent manner.
● One person's behaviour care plan identified that the person could become physically aggressive. Information was not provided on how that aggression presented and what worked well to de-escalate the aggression. The care notes for this individual also reflected that they were seen by the older people's mental health team in October 2019 who recommended to stop one of their medicines if they presented with further signs of agitation, as the side effect of this medicine was agitation. A GP review was carried out in November 2019 documented that the GP had increased the person's anti-psychotic medicine due to feedback from the staff team that they were presenting as more agitated. The advice from the older people's mental health team had not been followed.
● We discussed these concerns with the registered manager as the person's daily notes failed to reflect any

incidences or evidence of recent agitation. The registered manager identified one diary entry note which referred to the person presenting as agitated but was unable to explain why the GP was informed that the person was presenting as more agitated and why the advice from the mental health team had not been followed. This meant the person's dosage of anti-psychotic medicine had been increased when their agitation could have been the side effect of one of their other medicines. Subsequent to the inspection, the registered manager advised that they had organised for the GP to review the person's medicine and re-iterated to the staff team about the importance of recording any agitation noted. Additional feedback from the operations director following the inspection confirmed that the GP reviewed the person medicine and the person was no longer prescribed the medicine.

● Where incidents of challenging behaviour had occurred, staff were still not always using monitoring and recording systems effectively, so it was not evident that people had been supported safely. ABC charts are a tool to record what happens before, during and after an episode of behaviours that may challenge. Staff had not consistently completed these with sufficient detail, so it was not always clear how the person had been supported to de-escalate and what had been occurring beforehand. This increased the risk of people not receiving appropriate support.

● The registered manager confirmed that ABC charts were not reviewed to identify any trends, themes or patterns if the support provided to the person was working effectively. One person's ABC charts identified nine incidences in October 2019. Staff had recorded the behaviour as 'trying to stand up, wanting to go home, agitated.' The ABC charts also reflected that the person presented with these behaviours in the afternoon, usually between 14.00pm – 18.00pm. The failure to analyse and review ABC charts left this person at increased risk of not receiving the right support. Another person's ABC chart reflected 29 incidences of behaviours which challenged between 17 October to 9 November 2019. However, the registered manager advised the inspection team that this individual was more settled, and their medicine had been reduced due to the person presenting as more settled. The documented ABC charts failed to reflect the registered manager's feedback.

● The ABC charts for another person reflected weekly episodes of challenging behaviour. The level of detail recorded in the charts was poor. For example, some of the entries referenced possible physical aggression but the actions of staff were unclear. This increased the risk of harm to the person as the management team were unable to effectively monitor the person's behaviour and review whether the current arrangements were meeting the person's needs.

● Where staff had completed ABC charts, they did not consistently tally with people's daily records. For example, one person's daily records reflected that they were settled, yet ABC charts reflected periods of behaviours which challenged. There were also no corresponding incident forms completed for incidents where the person had displayed behaviours that may challenge others. For example, the ABC charts for one person during the period October to November demonstrated incidences of them throwing furniture in the communal area. Corresponding incident forms had not been completed.

The failure to provide safe care and treatment was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Other risks were managed well. At the last inspection in May 2019, risks associated with choking were not safely managed. This was because staff lacked knowledge on how to safely support a person during a choking incident. At this inspection, some improvements had been made. People had individual choking risk assessments in place. Staff were able to confirm where the service's de-choker devices were located and how to use them. Staff demonstrated an understanding on the steps to take to minimise the risk of aspiration, including ensuring people were sitting in the upright position. This was observed on the inspection. Staff had received training on how to use the de-choker and their competency had been assessed.

● Incident and accident records confirmed that there had been no recent choking incidents at the service. Choking risk assessments identified the need to administer abdominal thrusts to people in the event of a choking incident before using the de-choker device. However, guidance on how to administer abdominal thrusts to people in a wheelchair was not reflected in their risk assessment and staff were unable to relay how they would carry out that procedure. We brought this to the attention of the management team to address who agreed to discuss this with staff and provide additional training.
● Many people at Forest Lodge continued to require support to manage risks associated with their mobility and manual handling support needs, including risks of falls. Staff had supported people to receive additional support from specialist internal and external physiotherapists and the community falls teams to help assess and provide guidance about how to support people as safely as possible. At the last inspection in May 2019, concerns were identified that staff were not always following this guidance and placing people at risk.
● At this inspection improvements had been made. Staff were observed supporting someone to move and transfer using a hoist. Staff explained the process beforehand and explained every step to the person as well. Moving and handling risk assessments were in place which considered how to promote a safe transfer, the equipment required and factors which might impact on the transfer, such as osteoporosis.
● Care and support was provided to a number of people at risk of skin breakdown. Risk assessments were in place which considered how to promote healthy skin, any equipment required such as a profiling bed, pressure relieving equipment and if the person required regular re-positioning. No one was living with skin breakdown at the time of the inspection.

Staffing and recruitment:
● At the last inspection in May 2019, concerns were identified that the induction for agency nursing staff was not robust and agency staff had not been given time to access and discuss information about how to support people's individual needs safely before assuming control of leading the shift. This had meant they were relying exclusively on speaking with other staff or locating documents themselves if needing information. This increased the risk that there might be an undue delay in providing people with support they needed to keep them safe. At this inspection, improvements had been made.
● Agency nursing staff told us that they felt well supported and that the induction was a lot more robust. Agency nursing staff also commented on the revised handover sheet which included key information on people's needs. One agency nursing staff told us, "It's a lot better now, information is accessible, and I feel confident that I can support people safely."
● There were safe systems and processes for the recruitment of staff. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Barring Service (DBS) and obtaining suitable references. Nurses deployed were checked by the registered manager and provider that they were registered with the Nursing and Midwifery Council (NMC) and were fit to practice.
● Staffing levels were based on people's individual needs alongside the skill mix of staff. The registered manager completed a shift planner for each shift which considered the deployment of staff and that staff with the right skills and training were on each shift. People and their relatives felt staffing levels were sufficient. One relative told us, "There always seems to be plenty of staff."
● Staff confirmed that the service was busy but that staffing levels were safe. Observations of care demonstrated that call bells were answered promptly and people's requests for personal care were also attended to promptly.

Using medicines safely:
● At the last inspection in May 2019, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because medicines were not managed safely. People had

not received their medicines due to errors in re-ordering stock. People did not always have accurate, up to date or detailed protocols for when to offer and administer any prescribed 'as and when required' (PRN) medicines. Medication Administration Records (MAR) had not always been completed to record when PRN medicines had been given and the reasons why. At this inspection, improvements had been made.

● People received their medicines on time and in a dignified manner. Medicines were administered by registered nurses who received regular training and had their competency assessed. Nursing staff were aware of good practice guidelines and this was observed in practice. When administering medicines, nursing staff demonstrated patience and kindness. They explained to the person what their medicine was for, ensured they had a drink to hand and stayed with the person whilst they took their medicine.

● Protocols were now in place for the use of 'as required' medicines and MAR charts were completed accurately and included the reason for administration on the back of the MAR chart. Mar charts reflected that the use of anti-psychotic medicines in the service was minimal and where people were prescribed as required medicines to help manage their behaviour, these were rarely administered. A sink had also been installed in the clinical room on Beech Unit which meant the risk of cross infection had been mitigated.

● Systems were in place for the safe storage, ordering and disposal of medicines. Regular medicine audits took place and systems were in place to regularly monitor stock levels.

Preventing and controlling infection:

● At the last inspection in May 2019, the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider had failed to ensure adequate cleaning took place to combat odours caused by incontinence. At this inspection improvements had been made.

● The registered manager told us that carpets within the service had been replaced and an infection control lead had been appointed alongside infection control champions. The service was also receiving support from the provider's quality assurance team. Monthly infection control audits were also completed.

● The service presented as clean and tidy with no malodours. The service had a dedicated housekeeping team and relatives told us that they felt the service was clean and tidy. Staff had access to personal protective equipment (PPE) and hand sanitisers were available throughout the service.

Learning lessons when things go wrong:

● The registered manager monitored incident and accidents on a monthly basis. A monthly report was also produced which considered the number of unplanned hospital admissions, infections acquired, pressure ulcers and safeguarding concerns. The registered manager was open and transparent. Following a recent safeguarding concern whereby agency nursing staff failed to record when they administered pain relief to a person, the registered manager undertook supervisions with staff and completed spot checks to ensure ongoing learning.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. This was because the provider was not working in line with the principles of the Mental Capacity Act 2005. Suitable numbers of staff were not sufficiently deployed, and pre-admission assessments lacked detail. At this inspection this key question has remained the same. Improvements had been made but ongoing work was required to further embed the improvements. The principles of the Mental Capacity Act 2005 were still not being met. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- At the last inspection in May 2019, the provider was in breach of Regulation 11 of the Mental Capacity Act 2005. This was because decision specific mental capacity assessments were not in place. This included decisions around the use of shared bedrooms. At this inspection, we found that capacity assessments were now in place for use of shared bedrooms. However, for other specific decisions, capacity assessments had not always been completed. For example, one person's care plan referred to their wardrobe being locked. This was documented as part of their behaviour management strategy. However, their capacity to consent to this decision had not been assessed and a best interest meeting had not been held to determine that this practice was the least restrictive option.
- The registered manager was in the process of having best interest meetings with relatives and healthcare professionals where people lacked capacity to consent to the provision of their care. The meeting minutes of these best interest decisions demonstrated that the use of bed rails and sensor mats were discussed. However, people's ability to consent to the use of these restrictive practices had not been assessed. Therefore it failed to assess in the first instance to what extent the individual could give consent in those decisions before involving others in a best interest process. The provider and registered manager were unable to demonstrate how they were working in line with the principles of the MCA 2005 in order to protect

people's rights and implement least restrictive interventions . We discussed these concerns with the registered manager who identified that the Mental Capacity Act was an area of work they were focusing on.

The failure to work in line with the principles of the Mental Capacity Act 2005 was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● DoLS applications had been made where required and conditions attached to people's authorised DoLS were being met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● At the last inspection in May 2019, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because pre-admission assessments lacked detail. Assessments did not always include details about the specifics of the support people needed in all areas of their lives and why this was. Assessments also lacked detail about how best practice guidance informed the support people needed, or what people wanted from their support. At this inspection, improvements had been made. However, ongoing work was required to embed good practice and further work was required to ensure the pre-admission assessment gathered all required information.
● Before a person moved into the service, the registered manager or a member of the management team carried out a pre-admission assessment. This assessment considered the person's social, emotional, physical and mental wellbeing. Whilst a variety of information was gathered, information was not consistently gathered on how the person's dementia presented, and the specific support required around their dementia needs. This increased the risks that a person's specific needs would not be well understood or met. This is an area of practice that requires ongoing improvement.
● The provider was using nationally recognised, evidence-based guidance to track and monitor people's health outcomes, such as Waterlow charts to ensure people's skin was healthy and MUST (malnutrition universal screening tool) tools to monitor people's nutritional needs.

Staff support: induction, training, skills and experience: Supporting people to eat and drink enough to maintain a balanced diet:
● At the last inspection in May 2019, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff were not suitably deployed. The lunchtime meal was chaotic and nurses administering medicines routinely broke off from their tasks to help support people to eat and routinely interrupted people's mealtime support to administer medicines. Some people waited for extended periods before being supported to eat, with no consideration as to how to keep their food warm. At this inspection, improvements had been made and legal requirements now met.
● People were now able to choose from having their main meal in the dining room or alternative areas in the service, such as the dining room. Nursing staff also supported people to have their medicines after their lunch time meal. This meant nursing staff could provide assistance and support during lunchtime.
● With permission we joined people for their lunchtime meal. Music was playing softly in the background and tables were neatly decorated. The menu was on display and people's lunch were served on bright coloured plates to aid orientation. Staff provided assistance and support when needed. For example, one person was observed getting up from their table before their meal had arrived. Staff gently took their hand and enquired if they wanted to sit elsewhere. Together they walked around the dining room exploring where the person could sit.
● Staff worked in partnership with healthcare professionals such as dieticians and Speech and Language Therapists (SaLT). Specialist diets were catered for and where people were at risk of malnutrition, nutritional supplements were provided, and the chef provided fortified food to promote calorie intake. The service had a hydration station to promote fluid intake and staff were regularly observed supporting people to eat and

drink.
● People spoke highly of the food provided. One person told us, "I never have a grumble here, very good food." Another person told us, "The food is very good."
● An ongoing training programme was available to staff and staff new to the care sector were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their induction into working in health and social care. Staff spoke highly of the training provided. One staff member told us, "I really enjoy the training and I enjoy putting the training into practice."
● Staff received training which was specific to the needs of people. For example, nursing staff had received training in diabetes and catheter care. Staff had also received dementia care training. Staff received ongoing supervisions and nursing staff had their competency regularly assessed to ensure they remained skilled and competent to meet the needs of people.
● People and their relatives felt staff were skilled and competent. One relative told us, "The staff all seem to have the skills to care for her." One person told us, "The staff are very good and do have the skills to look after me."
● Observation of care demonstrated that staff treated people with kindness and patience. Staff told us how they recognised the importance of human touch and this was observed on the inspection.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
● People received ongoing support from a range of healthcare professionals, these included GPs, psychiatrists, older people's mental health team, physiotherapy and SaLT. However, following a psychiatrist review, the recommendations for one person had not been followed up. We have commented more on the failure to follow recommendations in the 'Safe' section of the report.
● Staff used a standardised system for recording and assessing baseline observations of people's health indicators. This included temperature, pulse, blood pressure and respiratory rates. The system was called National Early Warning Score (NEWS). NEWS was designed to ensure that people's health needs were effectively monitored and, if necessary, people could be supported to receive or access healthcare support and services quickly. Staff were expected to complete NEWS as and when required, if they noticed a person appeared or was unwell. From records we sampled, we saw that this system was being used appropriately at the time of the inspection. For example, staff noticed that one person was presenting with the signs of a stroke. Nursing staff completed a NEWS score and 999 was contacted immediately.
● Relatives spoke highly of the support their loved one received. One relative commented, "She gets the care and attention she expects and deserves, I am very happy with her care here." Another relative told us, "He gets the care and attention he needs. The Doctor visits regularly and I'm always informed of any chest infections or illnesses."
● Care and support was provided to a couple of people living with a catheter. Care plans and risk assessments were in place. Support was provided to change people's catheter bag every 12 weeks and staff monitored people's fluid and urine output to monitor for any signs of infection.

Adapting service, design, decoration to meet people's needs:
● At the last inspection in May 2019, a recommendation was made that the provider sought advice and considered how to improve the design and adaptation of the home and outside spaces to better meet the needs of people and promote the independence of people.
● At this inspection we found that steps had been taken to improve accessibility to the garden which meant people could now access the garden independently. The registered manager also confirmed that a gazebo had been built in the garden and during warmer months, a number of activities took place outside under the gazebo.
● The service had a large communal lounge where people could spend time with each other or with visitors.

There was a separate 'library' that had been decorated with wallpaper depicting shelves of books. There was a separate 'memory' room, that had been decorated with items and pictures from the 1940s and 1950s, including a replica of a village shop from this period. At the last inspection in May 2019, staff commented that these areas of the service did not get used much and were not thought particularly beneficial to people's needs. At this inspection, we found the 'memory room' was being used for small group activities and a number of people enjoyed their meals in the 'memory room.'

● Staff identified that further work was required around the use of the 'memory room' and ensuring it was beneficial to people's needs. For example, staff commented that more reminiscence work could be undertaken, and further work could be done to fully support people to engage with the items of memorabilia in the 'memory room.'

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. This was because where people shared a bedroom, consideration had not been given on how their dignity and privacy should be respected. At this inspection this key question has remained the same. Whilst some improvements had been made. Further work was required to improve the culture of the service and ensure people received care that was safe and person centred. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence:
- People were not always supported in a safe, dignified and person centred manner. We found areas of practice whereby people were at increased risk of receiving inappropriate and inconsistent support. For example, where people displayed behaviours which challenged, people were at heightened risk of receiving unsafe care and the risk of restrictive practice had not been mitigated. We have further reported on these concerns in the 'Safe' domain of this report.
- At the last inspection in May 2019, concerns were identified that where people shared a bedroom, consideration had not been given to their dignity and privacy. Risk assessments could not be located which meant there was continued lack of documentation and risk that staff may not be ensuring people's privacy and dignity needs were respected whilst sharing a room.
- At this inspection, improvements had been made. Care plans and risk assessments were now in place on sharing a bedroom. Staff told us how they would inform one person if they were supporting the other person with personal care. Staff and registered manager confirmed that people who shared a room got on with the person and enjoyed their company.
- Staff members gave us examples of how they maintained people's privacy and dignity when they supported them with personal care. One staff member told us how they ensured that curtains were closed, and doors shut. They also explained that when supporting the person to wash their lower half they would ensure their top half was covered.
- People and their relatives confirmed that staff respected privacy and dignity. One person told us, "Staff are very kind and caring, [they] treat me with dignity and respect." One relative told us, "The staff are very kind and caring, absolutely she is treated with dignity and respect, I have not observed anyone treated with less."
- Staff recognised the importance of promoting people's independence. One staff member told us, "When supporting a person with personal care, I will always encourage them to do as much for themselves as possible. I will ask, do you want to wash your face if I wash your back."
- Staff interacted with people using humour and people responded to staff with smiles and laughter.

Ensuring people are well treated and supported; respecting equality and diversity:
- People's cultural and spiritual needs were respected. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent in privacy. Faith based services happened regularly at the service which people could choose to attend or decline.

● People and their relatives spoke highly of the staff team. People confirmed that staff treated them well and treated them with kindness and compassion. One person told us, "The staff are very kind and caring." One relative told us, "The staff are very kind to him, they all seem to like him and make a fuss of him."
● People told us staff knew their preferences and cared for them in the way they liked. Staff we spoke to knew people's life histories and individual preferences. Staff were prompt to recognise people's needs and signs of distress. For example, during the inspection one person was observed to be upset. Staff promptly recognised their signs of distress and provided reassurance, enquiring if they wanted to go and visit one of their friends upstairs. This reassurance calmed the person and they were supported to go and visit their friend.
● Staff recognised the importance of psychological support. People had items of importance to hand and staff were aware that these items provided reassurance to people. Staff were observed handing one person their teddy bear which the person immediately hugged and thanked the staff member.
● Visitors were made to feel welcome and relatives told us that they could visit at any time. One relative told us, "We are always made to feel welcome. It's such a welcoming and homely atmosphere. Everyone says hello and we can visit whenever we want." During the inspection, a number of relatives visited the service. Relatives also visited with pets which people enjoyed. On the day of the inspection, one relative visited with their dog. The dog was a key talking point for many people and people enjoyed chatting with staff about the dog.
● Staff recognised the importance of companionship and supporting people to make friends with other people living at the service. One staff member told us, "We always look out for how people are feeling and offer emotional support. We supported one person who suffered a bereavement to make friends within the service which really helped them."

Supporting people to express their views and be involved in making decisions about their care:
● Relatives confirmed staff involved them when people needed help and support with decision making. People and relatives told us they felt listened to. One relative told us, "I have been impressed by the communication from them about my mother."
● Staff recognised the importance of supporting people to be involved in decisions about their day to day care. Staff told us how they communicated effectively with people in order to empower them to make day to day decisions. One staff member told us how they provided people with choices but not too many choices and visual aids worked well. For example, showing people their clothing options.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. This was because activities offered were generic, group based, and similar activities were offered on a rolling basis month by month and these did not always reflect people's individual's areas of interests. There was a lack of available transport and drivers. This meant that people had not been able to receive regular support to attend social events or meet people with similar interests from the wider community. At this inspection, this key question remained the same. Some improvements had been made but further work was required to ensure activities remained person centred. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences: Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them:

● At the last inspection in May 2019, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because activities offered were generic and access to the community was limited. At this inspection, some improvement had been made but ongoing work was required.

● Care and support was provided to a number of people receiving care in bed. Social care plans were in place, but these failed to identify if the person was at risk of social isolation. For example, the care plan for one person identified that they liked to eat their lunch in the main dining room so that they could meet other service users. Their care plan also referred to staff encouraging the person to join in activities. During the inspection, this person was observed as remaining in bed and also received their meals in bed. Staff told us that this individual was spending more and more time in bed due to a deterioration in their health. This was not reflected in their care plan and consideration had not been given to their psychological and emotional needs.

● Consideration was not always given to people's environment when people preferred to stay in their bedroom or receive care in bed. Some bedrooms were personalised with pictures and ornaments, whereas other bedrooms were bare, with little detail and few images on the wall. We spent time with one person who remained in bed throughout the inspection. Their TV remote was not to hand and due to the positioning of their bed they faced their wardrobe. The walls in the bedroom were painted a pale colour and their window was behind them. Their social care plan failed to consider their environment and whether the risk of social isolation was being mitigated.

● Activity staff told us that they provided one to one activities with people and for people who remained in their room, they would sit and chat, provide hand massages or read to them. Activity staff had also implemented a recent initiative whereby note books had been placed in people's bedrooms. The purpose of these note books was for staff to record when they popped in and had a chat. Activity staff commented that through the note books they would be able to monitor how much interaction a person was having. Whilst activity staff provided one to one support, the care planning process failed to consider and regularly review if the provision of activities was meeting the person's need and reducing the risk of social isolation.

● Since the last inspection, the registered manager had implemented activity logs. These were completed

daily and considered if the person participates in the activity, declined and any other comments. This information was not used in the review of activities and social care plans. For example, where's people had consistently declined to engage in activities, there was no consideration as to whether changes were needed to the activity schedule to ensure people's level of participation and enjoyment improved.

● Since the last inspection in May 2019, information had been gathered on people's likes, interests and activities they enjoyed. Activity staff told us that this information was used to help devise and review the programme of activities. Whilst a range of activities were available, these were not always reflective of people's hobbies and interests. For example, one person's record identified their interest in snooker and darts. This was not factored into the activity programme.

● Where people received funded one to one, activity logs and social care plans failed to reflect and consider if the provision of activities was meaningful and meeting their needs. For example, one person was funded for one to one care for 24 hours. Their social care plan failed to reflect that they received this funded care and how best to utilise the hours to meet their social needs. Activity logs demonstrated that they occasionally participated in group activities but failed to demonstrate what one to one activities took place. Documentation also reflected that they had only accessed the wider community once in the last four months, despite receiving one to one funded care. The care planning process failed to holistically consider and assess if the provision of social care was meeting the person's needs.

● The service had a mini-bus and weekly trips out were organised. Concerns were identified at the last inspection that the service only had one driver and people who required support to access healthcare services were prioritised when planning travel arrangements over community activities. Activity staff confirmed that another part time driver was required, and community-based activities were planned around healthcare appointments. However, meeting minutes from October 2019 identified that access to the mini-bus was not always available which impacted on community trips out.

● The limited availability of drivers also meant that people's ability to access the local community on a one to one basis with staff was limited. For example, one person's care plan identified that they enjoyed a monthly shopping trip. Their activity log for November 2019 failed to evidence whether this trip was offered, if the person declined or if the person went out.

We recommend that the provider seeks guidance and advice from a reputable source about the provision and evaluation of person centred activities for people at risk of social isolation.

● Other areas of care were responsive, and person centred. Steps had been taken since the last inspection to improve the range and availability of activities. Activity staff confirmed that smaller group activities were now taking place which was observed on the inspection. For example, a number of people were observed engaging in a cookery class.

● A variety of activities were on offer which included bingo, arts and craft, music and movement, pet pals, flower arranging, coffee mornings and various entertainers visiting the service. During the inspection we observed a music and movement class. People were observed engaging in the class and enjoying the music played. Other activities were also observed. One staff member was observed spending time with three people looking at old pictures and supporting people to talk about their past and previous interests.

● People told us that activities were available. One person commented, "I enjoy taking part in the activities, I like music and quizzes." Another person told us, "I do my best with activities, I enjoy most of them, I am going out on a trip today, it will be a surprise."

● Concerns were raised at the last inspection that care plans lacked personal information, such as people's likes, interest and hobbies. At this inspection, improvements had been made. Care plans included information on people's interests and life history. Feedback from a visiting healthcare professional included, "I've found the care plans to be personalised and key information accessible."

Meeting people's communication needs:
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● At the last inspection in May 2019, people's care plans recorded information about their preferred method of communication, including consideration of how best to share information for people may have a disability or sensory loss, information about people's care was not always available to people in the most accessible format. At this inspection, we found some improvements had been made but ongoing work was required.
● Information throughout the service was displayed in pictorial format including the menu and activity planner. A copy of the complaints policy was also displayed in pictorial format.
● Care plans included information on people's communication needs. However, where people had a sensory impairment, consideration was not always given on how information could be presented. For example, one person was registered blind. Their care plan identified that information should be provided in English language. However, no further information was provided. Information was not available if the person required letters to be read to them. If they could read braille and if they had input from the blind society. Staff told us they supported the person by reading things out aloud to them.
● Care plans were reviewed monthly and relatives confirmed they were involved in the care plan review. One relative told us, "They keep me updated and contact me to discuss care plan reviews." However, where people had no immediate relatives, the care planning process failed to consider their involvement and care plans were not always presented in a way that people could easily understand. The registered manager told us that they recognised documentation and accessibility needed to improve and that this was something they were focusing on.

Improving care quality in response to complaints or concerns:
● People and their families knew how to make complaints; and felt confident that these would be listened to and acted upon in an open way. One relative told us, "I've never had to complain but if I did, I wouldn't hesitate in going to the manager." One person told us, "I'm very happy here but any concerns I would go to the manager."
● People said staff listened to them and resolved any day to day concerns. The provider had a complaints policy and procedure that was on display. We saw evidence that complaints received had been responded to and managed appropriately.
● The staff team and registered manager had received a number of compliments since the last inspection. Comments included, 'we would like to say a big thank you to you all for the care that you gave Mum in the time she was with you. A big thank you to the staff team for their dedication in the care of Mum.'

End of life care and support:
● Staff had received end of life training. One staff member commented, "I think it's important that people receive dignified care at the end of their life. You need to make sure they are comfortable, not in any pain and I think it's important to sit and hold their hand."
● A visiting relative spoke highly of the end of life care provided to their loved one. They told us, "My mother died here two years ago but I still visit here, they were just lovely, helpful, supportive and marvellous here; I felt Mum was safe and well cared for. I never felt anything other than she got the best care, and they looked after us as well, she was happy here."
● Staff recognised the importance of supporting family members at difficult times. Staff attended the funerals of people who had passed away at the service and remembrance services had also been held at the service.

● Advanced care plans were in place which considered the person's resuscitation status and if the person wanted to be transferred to hospital in the event of their health deteriorating. However, care plans were not personalised and did not include specific information on people's wishes regarding end of life care. For example, if they want any music playing, who they wished to be present and what was important to them. The registered manager told us, "We are aware that end of life care plans need more information and need to be more personalised. This is something we are working on."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. This was because quality assurance systems were not always effective. Audits did not always identify or record the actions required to address any quality issues, how these should be prioritised and when they should be completed by. At this inspection this key question has remained the same. Some improvements had been made. The provider had been working in partnership with the Local Authority and action plans were now in place. However, the provider's quality assurance framework was not always effective in driving and embedding improvements. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care:

- At the last inspection in May 2019, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because quality assurance systems were not always effective in driving improvement. Audits did not always identify or record the actions required. A centralised development plan was not in place.
- At this inspection, we found quality audits had been completed and had identified issues raised at our last inspection, but not enough action had been taken to demonstrate improvements. For example, the provider's internal quality assurance team carried out an audit in September 2019 and identified that ABC charts required analysis to identify trends, themes and patterns. However, there had been no recorded progress on this action and at our inspection we found that the registered manager and management team still lacked oversight of ABC charts.
- Care plans were reviewed on a monthly basis; however, these monthly reviews failed to identify shortfalls with documentation or identify how the care planning process could be improved. For example, two people's care plans identified that they were living with depression. A mental health and well-being care plan was in place and reviewed monthly but the care plan failed to consider what support people needed around their diagnosis of depression.
- Reviews of people's needs, and care plans failed to identify inconsistencies within the care planning process. For example, one person had a behavioural intervention plan completed by the providers positive behaviour lead. This intervention plan included clear information on the root cause of the person's behaviour. However, this information was not translated or referred to in the person's challenging behaviour care plan. The management of how to support the person when they displayed behaviours which challenged differed between the two plans. This increased the risk of the person receiving inconsistent support.
- Quality assurance audits failed to consistently identify how documentation could be improved. Since the last inspection, the provider had implemented guidance for people who shared a bedroom. However, this guidance was generic and not always personalised. For example, one person's shared bedroom risk assessment failed to consider their diagnosis of dementia, that they were living with depression and also

experienced confusion. This person's sleeping care plan identified that they required regular checks at night. Yet, there was no consideration on how this might impact on the person they were sharing a room with.
● Sexuality care plans were in place, yet these lacked detail and information. For example, information was not available on how people were supported to spend time alone with their loved one.
● Care and support was provided to a number of people at risk of constipation. Constipation risk assessments were in place along with elimination care plans. Staff regularly monitored people's bowel movements and where people went a period of time without a bowel movement, medicines were in place to support the person. However, the care planning process failed to provide information on how to promote healthy bowels and what the person's usual routine looked like. Monthly reviews of care plans failed to identify this shortfall.
● Hospital passports were in place (a healthcare passport is a document about a person and their health needs). At the provider's last inspection in May 2019, it was identified that hospital passports lacked detailed and were not always completed correctly. At this inspection, we found that hospital passports had been reviewed. Whilst they had been reviewed, information was still missing, and the review process had not always identified shortfalls with the information recorded. For example, one person's hospital passport identified that they could eat independently without staff supervision. However, staff confirmed, and their care plan identified that they required supervision from staff when eating. Another person's hospital passport failed to reference their risk of physical aggression. This increased the risk of people not receiving appropriate support during a hospital admission.
● Since May 2018, the provider has been in continued breach of Regulations 17 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Despite action plans and various audits, these ongoing concerns have not been remedied. This had left people exposed to risk and poor-quality care in some areas.
● Since November 2015, Forest Lodge has been inspected on five different occasions. At each inspection, the provider has failed to achieve a rating higher than Requires Improvements in the domain of 'Well-Led.' Concerns regarding the ongoing safety of the service have remained. Out of five inspections dating back to November 2015, the provider has only achieved a rating of 'Good' in the 'Safe' domain once and this had not been sustained. Quality assurance audits were not consistently effective in driving, embedding and sustaining improvement.
● Following our last inspection in May 2019, we imposed conditions on the provider's registration which meant that every month, the registered manager had to send us a report providing information on how they were supporting people living with behaviours which challenge, falls and mobility needs. We reviewed the provider's first monthly report during the inspection. This report failed to identify the concerns we found regarding the management of behaviours which challenge.

The failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● A centralised development plan was now in place which enabled the registered manager and operations director to monitor ongoing actions identified from audits.
● The registered manager and management team had been working in partnership with the local authority. Feedback gathered from a member of the Local Authority market support team included, "We've seen huge improvements. They've really focused on activities and received a range of compliments. I feel the residents are safe and there's always a lively, friendly atmosphere here whenever I visit."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:
● The registered manager and management team were committed to improving and developing the service.

They were open and honest about the work still required but expressed dedication in improving the overall quality of care provided.

● Relatives, staff and people spoke highly of the registered manager. One staff member described the registered manager as 'exceptional.' One relative told us, "The manager is extremely approachable and easy to talk to her."

● Without exception, relatives spoke highly of the atmosphere at Forest Lodge. Relatives described the service as 'homely', 'welcoming' and 'always made to feel welcome.' One relative told us, "What I love about here is that no matter what, every staff member will say hello. The maintenance worker will stop and have a chat, so will the cleaning staff. I love that." Another relative told us how they moved their loved one to another care home due to funding reasons but after three days moved their loved one back to Forest Lodge, they told us, "Yes it is excellent here, we took her away to another home but we came back here, staff here are very good and are always with the residents, always somebody readily available,"

● The management team worked in partnership with people, relatives and healthcare professionals to achieve positive outcomes for people. The registered manager told us about one person who was admitted to the service with a grade four pressure wound. With input from healthcare professionals and support from staff, the wound healed within four weeks.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:

● The registered manager understood their responsibilities under the duty of candour and had kept relatives informed when something had gone wrong.

● The CQC's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website.

● The provider had a mission statement and set of values in place which governed the day to day running of the service. The operations director told us that the provider was re-looking at the governing values and that steps were being taken to enable people to devise their own values which underpin the day to day running of Sussex Health Care.

● The operations director was working in partnership with the provider's quality team and registered manager to drive improvement. The operations director told us about a number of new initiatives they were in the process of rolling out. These include weekly meetings with the registered manager to discuss their service improvement plan. HR (human resource) clinics to be held at the service monthly to help aid staff retention. Weekly community meetings with people living at Forest Lodge and risk and learning meetings were to be held.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others

● Forums were in place to involve staff in the running of the service. Regular staff meetings were held whereby staff could discuss ideas and raise concerns. Daily handovers were utilised for staff to receive key information. Since the last inspection in May 2019, the registered manager had amended the handover to include more key information. Staff spoke highly of the amended handover and how it was helpful having access to key information.

● Satisfaction surveys were sent out to relatives to gain their feedback. Findings from the recent survey in November 2019 found that relatives were happy with the care provided to their loved one. Comments from the survey included, 'I would recommend the service.'

● 'Resident' meetings were held on a regular basis and people were asked on their feedback on the activities provided and also provided with the opportunity to raise any concerns.

● Links with the local community were in the process of being established. Activity staff were beginning to access a local memory café and were also supporting people to attend a local luncheon club. However,

ongoing work was required to further strengthen community links.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person. Regulation 11 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not provided in a safe way for service users. Regulation 12 (1) (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13 (1) (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure compliance. Regulation 17 (1) (2) (a) (b) (c).