Forest Edge Care Home Limited

Forest Edge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Forest Edge is a residential care home providing accommodation and personal care to up to 32 people. The service provides support to older people who may be living with dementia, sensory loss, physical disabilities or mental health conditions. At the time of our inspection there were 27 people using the service.

Forest Edge is a care home accommodating up to 32 people in one adapted and extended building. The provider states on its website that it is a service, 'specialising in the care of those living with dementia, Alzheimer's and other cognitive impairments.'

People's experience of using this service and what we found
Staff did not interact with people and lacked an understanding of working with people living with dementia. We were not assured there was good infection prevention and control practice in the service, some areas would benefit from deep cleaning and other areas were in poor states of repair. Visiting was not taking place in line with government guidance. Visits inside the home had not taken place since before the pandemic.
Medicines were not always safely managed, we found medicines on the floor in a bedroom when we inspected.
Accidents and incidents were recorded however no post falls observations were completed when people had unwitnessed falls or had head injuries.

People's care were not completely person centred and lacked information such as life histories. Information was not always consistent and was at times contradictory.
People living with dementia were left unsupervised for over half an hour at a time, increasing risks of falls and potential harm from peers. Staff frequently returned people to their seats when they wanted to move about the service and tables were positioned in front of them.

Staff completed training in a range of areas however at least 50% of staff deployed were from an agency who only participated in fire training at Forest Edge. Other training was completed at their agency. In addition, none of the agency staff were participating in supervision when we inspected, one of the agency staff had worked there for seven years without supervision.

The décor and design of the premises did not reflect good practice guidance for a dementia care specialist service. The registered manager did not seek information or advice on how best to support people with dementia.

Staff we spoke with had no understanding of the Mental Capacity Act and records in people's care files indicated the management team also lacked knowledge of the Act. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible or their best interests.

People all had the same meals at lunchtime and while the registered manager told us there were other choices, we did not see a list of alternatives, or see staff offer people choices. One person was reported to have eaten and drank well, however we had noted she had not had a drink as she was not given her choice of drink and had eaten one sausage for her meal.

There was a lack of oversight of the service and audits completed did not give a clear insight into the service. The culture of the service was not always person-centred and staff did not spend time with people when they had the opportunity to do so. The provider had positive working relationships with some health and social care professionals. However, they had not made any attempts to develop links with local management groups or forums where they would benefit from sharing good practice and peer support.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 November 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about Mental Capacity Act assessments and best interest decisions, staffing, and people being vocal and unsettled for long periods without intervention. A decision was made for us to inspect and examine those risks and we undertook a focused inspection to review the key questions of name of safe, effective and well-led only. We also checked to see what progress had been made against breaches of regulation found at the inspection carried out on 24 November 2020. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Forest Edge on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to monitor the service and will take further action if needed.

We have identified repeated breaches of Regulations 9, 10, 12 and 17. There are additional breaches of Regulations 11, 13, 15 and 18.
Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Forest Edge

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience contacted relatives for feedback by telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Forest Edge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Forest Edge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of a monitoring activity that took place on 7 June 2022 to help plan the inspection and inform our judgements. We reviewed the information we already held about the service. We used all of this information to plan our inspection.

During the inspection
We looked at five people's assessments and care plans and reviewed their daily records. We reviewed documents relating to the health and safety of the premises and equipment and looked at 4staff files to ensure they contained all the necessary information. We completed multiple observations and spoke with five people and six staff to get feedback about the service. As part of the inspection, an Expert by Experience telephoned 10 relatives to gain their feedback about Forest Edge. We also contacted two health and social care professionals.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

• The providers website states, "With our team of highly skilled, enthusiastic individuals, we thrive in delivering high standards of person-centred care wherever possible. We take great pride in what we do and in making Forest Edge a place like home". We found people's experiences were not reflective of this statement.

• The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs at all times. At the time of our inspection there was one senior care worker and four care workers, the registered manager, the head of care, a cook and a member of domestic staff. At the time of our inspection 27 people were using the service.

• The provider's training record stated staff had received training in relation to dementia care, person centred care, mental capacity and diversity and equality. Observations carried out during our inspection and feedback from relatives did not support a judgement that staff were appropriately skilled or that they applied their learning in practice.

• On the first day of our inspection we identified occasions where staff failed to respond to people appropriately. For example, at 9am we observed one person repeatedly shouting, "I want to get out" and "I want to go home". By 9.17am, we observed one member of staff walk past the person's room three times without responding and a second member of staff walk past once without responding.

• At 9.18am we approached one of the staff members and asked why they hadn't entered the room to assist the person. They said, "She has dementia, she is always like this". We raised the lack of response to the registered manager who told us the person concerned had dementia and shouted regularly. The person's one-page profile stated they liked company and the television. The person remained alone in their room without a television on. This demonstrated a significant lack of skill, experience and response to provide care to someone who was living with dementia.

• We observed further lack of knowledge and competence when we saw another member of staff repeatedly moving a different person back to their chair where they consistently placed a table over their lap. The table restricted their movement and placed the person at risk of falling. We asked the staff member why they continually moved the person back to their chair. They said, "He has dementia and he is a risk".

• For long periods of time we observed the same member of staff standing by the door restricting people's access in and out of the lounge and not engaging with people in a respectful or approachable manner. This demonstrated the staff member was not appropriately skilled or competent in their understanding of how to care for people who were living with dementia, or how treat people with dignity and respect. We raised this with the manager and told them we had concerns about their training, their approach and their response. The registered manager told us they understood and then spoke with the staff member concerned.

• We saw some improvement on the second day of our inspection. However there continued to be minimal

interactions with people and they were consistently returned to seats when they got up to move about.
• Relatives told us they were concerned about staffing numbers. One relative told us, "There doesn't seem to be as many staff as there used to be. I used to know all the staff. I know the seniors, I don't seem to know the other people now, I don't know if they are agency or employed staff". A second relative said, "The biggest problem seems to be not enough people to answer the phone. You very often get an answering machine… it's not listened to. I have rung for two days solid they didn't answer the phone at all and so I left a message. On the third day someone picked up the phone… I feel very frustrated and have thoughts. One day when they didn't answer, I wondered if the place had burnt down". Another relative said, "Generally, but probably could do more. Always enough staff to open the door and when I phone, but it varies. Sometimes, I have to wait a while and sometimes they answer in seconds".
• A fourth relative told us, "No not really, sometimes when you arrive, you ring the doorbell. It can take ten minutes [for someone] to come to the door. When they have a break after lunch, there are two or three people or four staff who come out at the same time. When I was in the garden three were having a break and I walked around the corner and two others[staff] having a cigarette". We also observed the staff having a break at the same time after lunch leaving no supervision in the communal areas of the service. People were at increased risk of falls, becoming disorientated and of harm from others.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs at all times was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing.

• Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with adults, to help employers make safer recruitment decisions.

Preventing and controlling infection

At our last inspection the provider had failed to comply with guidance from the Department of Health about the prevention and control of infections. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• We were not satisfied the provider had effective arrangements in place to ensure the home and its equipment was properly cleaned and maintained.
• When we arrived on the first day of the inspection, we asked the registered manager to speak with us in an area which was private and confidential. The registered manager located a bedroom and told us nobody was living there. We asked when the room was last in use and when it had been cleaned and the last person moved out 10 days prior to our inspection and since then the room had been deep cleaned and repainted.
• We found the bedroom and mattress smelt strongly of urine and when we looked in the cupboard, we found stained and very worn bedding. We asked the manager if they could smell urine and they said, "Yes it does but nobody is in here, nobody is using the room". As the day progressed, the smell became stronger and more unpleasant.
• We found dried chewing gum stuck to the carpet on the stairway and dirt and dust in one of the bathrooms by exposed pipework. The sealant around the bathroom had eroded and the flooring was not properly maintained. We also found some tables used for assisting people to eat their meals were damaged and

worn. When we showed one to the registered manager, he said he would remove it from use. These shortfalls were an infection risk because the damaged surfaces meant they could not be cleaned properly.
• Whilst the registered manager had shown us cleaning schedules were in place, these were not consistently effective in maintaining a clean environment at all times.

This demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

• The registered manager told us they had identified work was needed in bathrooms and told us they had received various quotes to rectify the issues. These quotes were sent to us to demonstrate the registered manager was taking action. They had experienced problems in getting works booked in due to the pandemic.
• The provider had made efforts to increase their housekeeping staff by one but as yet had not been successful in this.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Using medicines safely
• We could not be confident that medicines were managed and administered safely. For example, at 10.13am on the first day of inspection we found two different tablets located on one person's bedroom floor. Their room was unattended and accessible as the door was left open. We reported this to the registered manager who visited the room and saw the medicine on the floor. He said, "Oh, that's not good is it? I will go and find out what it is and sort it".
• We returned to the service to complete our inspection a week later and asked if they had contacted the GP to ensure there would be no ill effects from the missed medicines. They told us they did not contact the GP as due to the person usually being cooperative with medicines there was unlikely to be any negative effect from missing a single dose. The medicines were believed to be an antidepressant and a medicine for hypertension; however, the management team were not able to be not certain of this. This placed the person at risk of harm from not receiving their medicines as prescribed. In addition, the registered manager had not undertaken any investigation or recorded the incident.

Procedures were not in place to manage missed or omitted doses of medicines or to ensure that medicines administered had been taken. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

• Accurate records were maintained of medicines received into the service, administered and disposed of. Medicine administration records (MAR) were completed as required.
• Where medicines were prescribed to be administered on an 'as required' basis, clear protocols to guide staff about the use of this were in place. Staff ensured medicines were reviewed with people's GP's on a regular basis.
• Staff told us they received training in medicines administration and that their competence was assessed on an annual basis, in line with national guidance. The registered manager provided us with five medication

competency records which suggested those who administered medicines were competent.

Visiting in care homes
• The provider was not currently following government guidelines. For example, in March 2022, care home visiting was only dependent on visitors having a clear lateral flow device test, LFD. The provider should have completed a risk assessment to address risks identified to facilitate safe visiting to service.
• When we inspected, the provider had retained a booking system for visiting and all visits were taking place in either an externally accessed room designated for visits or the garden. A large screen was also available for people who did not want to take an LFD test to visit behind. Visitors were not able to access the premises or they family member's rooms when visiting the service.
• This was in conflict with government guidelines and while retaining the booking system could prevent the premises becoming overcrowded, family members were concerned they had been unable to access the service in a very long period of time.
• A relative told us, "We have not been able to go since she went there in December, because of COVID-19. We have only been into the visitor's room or the garden, never been into the care home. I have emailed the registered manager, he said things should be changing shortly but the rules are we are not allowed in the care home, only the visitor room or the garden. Last time we didn't need to wear PPE or masks. We were not tested, they stopped testing on 31st of August. To me it's quite distressing… when they bring her to the visitor's room she is not in good form as she is very confused where she is and it takes her a while to settle. It's not good for her. I said we would like to visit in her room we haven't been allowed in there".
• A second relative told us, "We go to pick her up and they literally bring to the door and pick her up and drop off they greet her and take her off. I am curious as I do want to see what she is doing and what is happening. I feel we have gone past the COVID-19 thing and I feel we should be able to go in now. I've never seen the registered manager so never raised it. I have not had the chance to ask anyone".
• One relative was more positive about current arrangements telling us, "I have not been in since COVID-19, but you can't get a better care home. They won't let you in because of the COVID-19. I agree with what they are doing, it is better safe than sorry. I have a lateral flow test and I take her for a ride in the forest".
• Whilst it is understandable for the provider to be reluctant and nervous about opening the service to relatives again, it is essential that people and their relatives are able to visit to maintain relationships.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, dignity and respect.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• We looked at a range of different reports and noted several unwitnessed falls where people had no noted injuries and one where a person hit their head against a wall. While a call was made to the GP when the person hit their head, no post falls observations were completed. In incidents of potential head injury or unwitnessed falls, particularly when people living with dementia are not able to describe what has happened, good practice would be to complete observations. In a residential service this should include expressed pain and bruising developing and should involve waking sleeping persons to ensure they are not unconscious.
• Risk assessments had been completed about aspects of people's lives and wellbeing. Control measures had not always been followed, for example, one person should have their door alarm set when in their room. We accessed their room on more than one occasion and no alarm sounded.
• Risk assessments were mostly generic with all care records having in-depth hair dressing risk assessments for example. Holding a separate record of risks for activities such as hair dressing, podiatry and exercise sessions for example would negate the need for each person to have this in their record. Only specific individual risks could then be noted on people's records.
• We saw records of various accidents and incidents, however, at the time of our inspection no record had

been made of the medicines found on the floor.

Systems had not been established to monitor and mitigate risks to people following falls involving head injuries or unwitnessed falls. Risk assessments were not always followed and we were not assured all accidents and incidents were recorded. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

• Servicing and checks had taken place on equipment and fixtures at Forest Edge. The registered manager supplied evidence of checks on systems such as the fire alarm and water quality.
• The registered manager collated accidents, incidents and near misses each month and noted who had been involved, when the incidents had occurred and whether first aid or medical treatment had been needed.
• The registered manager told us they shared learning from incidents at staff meetings. However, since the COVID-19 pandemic started there had been no staff meetings therefore important information may be missed. The registered manager was reintroducing meetings soon and had used handovers and messaging to convey information.
Systems and processes to safeguard people from the risk of abuse
• The registered manager suppled us with a training matrix that showed safeguard training should take place every year. The record showed 13 of 15 staff had completed safeguarding training. Two staff had not completed the training, and 2 staff were overdue to refresh their training.
• A recent safeguarding allegation concerned people being seated with tables in front of them preventing them getting up. The provider stated in their response that the tables were on carpets and people could move them away should they want to, there was no one in the service unable to do this. We saw tables continued to be positioned in front of people and while people did manage to move the tables, they struggled and were restricted by them.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

• People had assessments and care plans in their care records. These were mainly generic with some additions of personalised information.

• A thorough life history is important when supporting people living with dementia as it can guide staff when people speak of their past and provide talking points such as family or interests. Each person's care record had a section for their life history, however we found just one completed life history in the five care records we looked at.

• Care plans did not always provide consistent information about people's needs and wishes. In one person's records identified they liked company and television in their one-page profile but had a social care plan recording their distress when with other people or watching television. We saw the person was very distressed in their room without stimulus or company.

• We saw no evidence of people contributing to their care plans or reviews. Relatives had contributed to the brief pre-admission assessment.

• Oral health training had been completed by most staff however there were no specific oral health care plans in line with good practice guidance. We asked the registered manager if people had oral health care plans and they advised this was included in other care plans. We found no evidence of this in any of the care records we reviewed. There was no evidence of understanding of the impact poor oral heath can have on general health or that good practice guidance had been taken.

• We spoke with the registered manager about oral hygiene and they told us they had problems accessing dental care for people since the start of the pandemic but that people were registered with a local hospital-based dentist.

People's care and care plans were not always person-centred or accurately reflected their needs and preferences. Good practice guidance on oral healthcare had not been followed. This meant people were at risk of harm. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care.

• We were concerned that people who were living with dementia were left unsupervised for periods of over half an hour at a time. People were at increased risk of falls, distress and harm from others when unsupervised. This was when staff were supporting people elsewhere and when staff took a break after lunch. We saw most staff took their break at the same time resulting in insufficient supervision of people.

• One or two care staff positioned themselves at the door to the lounge, leaning against the wall and talking to each other. They only briefly interacted with people when they tried to leave the room, turning them and returning them to their seats.
• We saw one person moving about the service in a distressed state. They repeatedly indicated, we believed to their incontinence pad by patting and rubbing their stomach. They were wearing just a nighty and a light dressing gown. The dressing gown was very stained in the back, it had been laundered but given back to the person with unpleasant staining on to wear again. This was due to the provider only having clothing supplied by families available. This showed a lack of concern for the persons dignity.

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, dignity and respect.

• People were supported to access health care professionals as required and referrals were made to relevant agencies when needed.

Adapting service, design, decoration to meet people's needs
• The premises was not fit for purpose in line with statutory requirements and failed to take account of national best practice. The providers website states, 'Forest Edge Care Home is a privately owned, 32 bed residential care home; specialising in the care of those living with dementia, Alzheimer's and other cognitive impairments' and 'We recognised that all human life, including those with dementia, is grounded in relationships, and that people with dementia need an enriched social environment that both compensates for their impairments and fosters opportunity for personal growth'. During our inspection we found people's experiences were not reflective of these statements and people were being placed at risk of harm.
• At the time of the inspection, the registered manager told us 23 people using the service were living with dementia. Symptoms of dementia may include memory loss, confusion and difficulty learning new things which means that someone with dementia may forget where they are, where things are and how things work. Appropriate lighting, safe flooring, contrasting colours, labels and signage and a safe outdoor space which is free from hazards can support people living with dementia navigate throughout the home safely and remain independent.
• The provider had failed to ensure the environment for people who were living with dementia was appropriate. For example, carpets were heavily patterned on the first floor and ground floor lounges, suitable lighting was not always in place and there was insufficient signage in communal areas, toilets and bedrooms to support orientation. Contrasting colours were not used and the majority of the home was painted white or cream. On one occasion we observed four people standing in the hallway. One person asked another if they were ok and the person said, "Oh dear, I just don't know where I am going".
• We fed our concerns back to the registered manager about the lack of understanding in terms of dementia environment and signposted them to consider best practice. We spoke with the registered manager when we returned to complete the inspection, they had reviewed the website we recommended and did not consider it relevant to their service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008)Regulated Activities) Regulations 2008, premises and equipment.

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 our last inspection the provider had failed to follow legal frameworks of the MCA. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

• At our last inspection, we found significant decisions were being made without following legal frameworks. For example, a decision was made for one person regarding how aspects of their behaviour should be managed by implementing specific restrictions on their freedom and choices. Their care plan stated this has been agreed with their husband. The husband did not hold a lasting power of attorney for health and welfare; therefore, a mental capacity assessment should have been undertaken and a best interests consultation facilitated by the provider. Other concerns related to potential restrictive practice with records not always documenting a least restrictive approach.
• The registered manager told us six people were subject to DoLS and said the assessments for 18 people were, "pending". None of the three staff we spoke with about MCA understood the meaning of DoLS. They could not tell us what restrictions were in place or what actions they should take when considering the least restrictive approach.
• During our inspection, we observed numerous restrictive practices. For example, on three occasions we saw one person stand up from their chair to go for a walk. The same member of staff responded by holding the person's hand and moved them back into the chair. On all three occasions the staff member then placed a table in front of the chair once they were sitting down. On a fourth occasion, the person managed to stand up from the chair and during this movement, their drink was spilt. The staff member ran towards the glass of juice to attempt to stop it falling. We asked the staff member why they continued to walk the person back to their chair and they said, "It's because he might hurt himself".

This demonstrates a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment.

• At this inspection, we identified further concerns people were not being supported in line with the MCA. For example, it was recorded one person lacked capacity to make the decision to have their coronavirus booster vaccination. Their care record stated, 'This individual has been deemed to lack capacity to make a decision on receiving their coronavirus booster vaccination' and 'It is agreed by the individuals next of kin that they have the coronavirus booster vaccination'. The same person was also considered to lack capacity to make a decision about having their flu vaccination. The provider failed to ensure mental capacity assessments had been completed for each of these specific decisions. Their records showed it was the next of kin who had authorised the decision for their loved one to have the vaccinations.
• As stated in our previous report, the next of kin does not have the legal autotomy to make a decision on a person's behalf. This should be assessed under the principles of the MCA. Other records relating to people's capacity to receive various aspects of care were also not properly assessed and documented. We fed this back to the registered manager.
• The registered manager sent us a training record which detailed training levels regarding MCA. The

document suggested two out of 15 available staff had not completed their training in this subject. Two staff were due to refresh their training, one of whom had not completed the training since 2017. The providers own training frequency states that MCA training should be every two years.
• We found a significant lack of understanding in staff knowledge when we spoke with them about the MCA. For example, when we asked a staff members to tell us about their understanding on the MCA and how they applied it when delivering care, one staff member said, "It's just about the way you behave, the way you do your things". A second member of staff said, "What is this, I am sorry I don't know, I don't understand" and a third member of staff said, "They (people) need love and patience" and "I help them to understand, begging, asking and convince them".

The provider lacked an understanding of how people should be supported in decision making and giving consent. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• The provider had a four-week menu plan displayed outside of the kitchen. Of 28 lunches 18 included creamed potatoes. Every tea was the same, 'selection of sandwiches, selection of soups'. We asked whether there were any other choices for people at mealtimes as when we observed lunch, everyone in one living area, was served with sausage, mash, mixed vegetables and gravy. The registered manager told us people could choose from a lot of different options however there were no menus available for people to hold and read and the alternative choices were not displayed for people to choose from.
• People ate their meals in their bedrooms or in armchairs in the lounge areas. There were no dining tables for people to sit up at to enjoy the social experience of mealtimes. A person who requested adapted cutlery was not provided with it. They said they had pain in their hands and needed the special cutlery. They had to be calmed before they ate and were reluctant to eat without the specialist cutlery. Whether the cutlery was physically needed or not, the person had expressed a preference and may have better nutrition if it was met.
• We saw staff give people their meals, sometimes cutting up items for people, without speaking with them. For people living with dementia, talking to them and telling them what is on their plate is important as it may stimulate their appetite.
• We were seated near to one person who ate one sausage, leaving all of their potatoes and vegetables. Staff removed their plate without attempting to encourage them to eat more. The person had told us they had lost some weight. We looked at the daily records for the person on the day we visited, and staff had noted they 'ate and drank well'. We were not assured the person completing the records had any knowledge of how the person had been that day and had written a standard phrase.
• When we inspected, we were told there was no one on a modified diet or using fluid thickeners. However, a relative told us, "[Person] struggles eating now, they don't want to eat. They are unable or too unwell to eat anything with lumps in and they only eat a tiny amount… They give them a full cereal bowl it's much for them and they don't want it. On Saturday a [care staff] gave them a bowl full, I couldn't get it to the tray without spilling it. I have raised it quite a few times over the years. I found it frustrating, they are not able to put a few spoons of food in the bowl."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014, person centred care.

• When people show signs and symptoms of swallowing difficulties or a reduced appetite, medical advice should be sought so referrals to dieticians or speech and language therapists can be made.

Staff support: induction, training, skills and experience
• The registered manager suppled us with a training matrix and a schedule showing supervisions that had

taken place with staff members. Supervision, or one-to-one sessions with line managers should offer opportunities for staff to receive support and guidance and to address any concerns or skills gaps.
• Some training took place annually, some was every two years or every three years. Most training was online. In addition there was a face to face dementia training course.
• We did not find any evidence that staff had completed the Care Certificate or progressed to complete any social care diplomas. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
• Just over 50% of the care staff team when we inspected were from an agency. The provider had used the agency for many years with one agency worker supporting people at Forest Edge for more than seven years.
• The service was a specialist dementia provider and as such we would expect to see staff trained to a high level of knowledge and expertise in the field however staff only completed a short face to face training session and an online training course.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. 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 our last inspection systems were either not in place or robust enough to ensure the quality and safety of the service was assessed and monitored effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, good governance.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

• The registered manager was also the nominated individual and had been in post since 2014. Two company directors were also involved in the service, one of them visiting approximately monthly.
• The management team consisted of the registered manager and a head of care who the registered manager described as their 'deputy manager in all but name'.
• The management team spent most of the inspection in the office of the service and unless they were providing us with information. We did not see them working on the floor. A relative told us, "He is approachable and pleasant but not necessarily doing anything." A second relative said, "I don't think he is very often there. I often ask to speak to him, he is never there. So my opinion is that he is not there, my impression is only a couple times a month."
• We had significant concerns about governance of the service. For example, there was a lack of awareness of staff conduct during the day, no research into best practice and developments in the area of dementia and a lack of knowledge of people living at Forest Edge.
• We had significant concerns about the oversight of the service after speaking at length with the registered manager. For example, they did not know where audits were stored, and needed the head of care to tell them which people did not have a lasting power of attorney.
• We found areas of the premises to be poorly maintained causing infection prevention and control risks, the décor was not suitable for people living with dementia, the premises were not as clean as they could be and some staff training was significantly out of date.
• Audits were carried out and had now been dated with the month and year they had been completed. Areas such as COSHH assessments being reviewed were noted however no action plans put in place to address the shortfall, 'No Action Req' being entered on the action plan document.
• Audits stated people were not disrupted by noise made internally. We found this was not the case, alarm bells were sounding constantly, particularly due to a staff member leaving the building and a door alarm continually sounding.

• Other areas audits did not accurately reflect were around odours in the premises, staff performance issues and the quality of their interactions with people and the premises design, layout and signage.
• None of the agency staff working at Forest Edge had participated in supervision meetings with Forest Edge senior staff. In addition, only service specific training such as fire safety had been completed by agency staff. Whilst we would not necessarily expect providers to supervise agency staff, these staff were permanently based at the service and were part of the team there and needed support, guidance and opportunities to develop in the same way as permanent staff. The registered manager also had limited knowledge and familiarity with 50% of their staff team. Since we inspected supervision and training provision for agency staff had improved.
• There was a lack of training and awareness of the Mental Capacity Act both in records and all staff knowledge. The registered manager and head of care responsible for care planning also showed a lack of understanding of MCA as records showed a lack of capacity assessments and best interest decisions.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure the quality and safety of the service was assessed and monitored effectively or that the registered manager had clear oversight of all aspects of the service. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, good governance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The culture was not entirely person centred and care plans did not all hold person-centred information that would enable staff to provide care specific to each individual's needs and wishes.
• There was no activities staff member, care staff provided activities during afternoons. While a specific activities person is not a requirement, there were limited interactions between staff and people. We saw people sat in lounges or their rooms from our arrival until after 2pm without any activities. In one area, people appeared to be able to chat with each other however in the other lounge, with the exception of a quiet radio playing there was no stimulus for people at all.
• We saw staff missed numerous opportunities to engage with people, choosing to stand with other staff members away from them or to give them food and drink without engaging in conversation.
• One person was particularly distressed and repeatedly approached the inspection team. We spoke with them and raised concerns about them with the registered manager. They told us that when they were discharged from a recent hospital stay, advice had been to not engage when they were upset as it may prolong the behaviour. This meant that when the person was upset, staff did not engage and throughout the first day of our inspection they were inconsolable.
• We saw one activity take place which was a type of chair-based exercise. We saw staff members speaking loudly, almost shouting at people and individually trying to get them to wave their hands in the air. There appeared to be no plan for the activity and people were not engaging with staff members. A second activity on a different day was a singer coming to the service to perform for people.
• People were seen to be self-stimulating by wringing their hands, rubbing their clothing and other fabrics and pacing. This can often mean they need something, such as access to the toilet, more opportunities to move about, or are experiencing pain for example. These indicators were not responded to by staff.

People were not always treated with dignity and respect and their needs were not always considered in a person-centred way. This was a breach of regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

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 provider understood their responsibility under the duty of candour and when something went wrong such as a fall causing injury, they contacted relatives to inform them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider had issued questionnaires to people and their relatives and had analysed the responses. There had been 23 responses from people who had been supported by care staff to complete their questionnaires. The registered manager had advised staff to use only factual information reading questions to people.
• There were three responses from 26 questionnaires sent to relatives, all agreed 100% with the service being safe, effective, caring, responsive and well-led.

Working in partnership with others
• We asked the provider for contacts of health and social care professionals we could contact for feedback about their service. Two health and social care professionals provided us with brief, mostly positive feedback about the service in terms of their working relationships with them and the referrals made to them.

• We spoke with the registered manager about who they worked closely with and apart from the GP surgery they had not forged working relationships with any health and social care professionals or community groups. The local Clinical Commissioning Group, CCG had provided weekly Teams meetings throughout the pandemic and ongoing. The registered manager said they looked at agendas and read minutes but did not participate.
• We asked if the registered manager had linked with any local social care managers groups or any on social media but they had not. The registered manager had limited support from within the provider and had not sought professional or peer support to enhance and inform them on best practice.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure care plans and records were accurate and person-centred, there was a lack of appropriate activities and staff consistently missed opportunities to engage with people. There were a lack of choices at mealtimes and food and fluids were not accurately recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to follow government guidelines on visiting and people had not been able to have unlimited visiting limiting their access to friends and family. People were left for long periods without supervision, people were sometimes ignored, always returned to seats if they wanted to walk and support was not given in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff had no understanding of the MCA and permissions and consents were given repeatedly by persons without the legal authority to give it.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We were not assured the provider had good standards of infection prevention and control. Medicines were not always safely administered, risk assessments were not consistently followed and accidents and incidents were not always reported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Restrictive practices were evident in the service and staff had no understanding of DoLS.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not suitable for provision of specialist dementia services.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not effectively provide oversight of the service.

The enforcement action we took:

Warning notice