

Shaw Healthcare Limited

Forest View

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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This unannounced inspection took place on 26 November 2018. Forest View is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Forest View is situated in Burgess Hill in West Sussex and is one of a group of homes owned by a national provider, Shaw Healthcare Limited. Forest View is registered to accommodate 60 people. At the time of the inspection there were 56 people accommodated in one adapted building, over two floors, which were divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. These units provided accommodation for older people with associated healthcare conditions as well as those living with dementia.

The home had a registered manager. A registered manager is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. The management team consisted of the registered manager and team leaders. An operations manager also regularly visited and supported the management team.

There were concerns about the provider's oversight and overall ability to maintain standards and to continually improve the quality of care. Areas of improvement that were found as part of this inspection had not been identified or acted-upon by the provider's own quality assurance audits. The provider had not learned from inspections of their other services and had not shared this learning to ensure that improvements were made across all their services. There have been consistent themes in relation to staff understanding of and the implementation of the Mental Capacity Act 2005 as well as timely access to medicines for people who have Parkinson's disease. Feedback about the leadership and management of the home as well as the approachability of the registered manager and the provider was not positive. Records did not always provide sufficient guidance to staff to inform their practice. Some, had not been completed in their entirety to confirm staff's practice and provide assurance that people had received the necessary support. These were areas of concern.

Not all people received their medicines in a timely way. Three people were living with Parkinson's disease that required their medicines to be given at specific times. Records showed that these people had not always had their medicines according to the prescribing guidelines. People were not supported in a person-centred way, in relation to their access to medicines, to ensure that their condition was well-managed. Not all risks to people's safety had been identified or mitigated. Not all chemicals or items that had the potential to cause people harm if ingested, had been stored securely. These were areas of concern.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible. The policies and systems in the home did not always support this practice. This was identified as needing to improve.

The provider had not always ensured that people's communication needs were met. They had not always documented people's communication needs to inform staff's practice. Resources and information were not always adapted to help people to access information or understand the information that was available to them. We have recommended that the provider seeks advice from a reputable source in relation to providing information for people to meet their communication needs.

People told us that they felt safe. One person told us, "It's safe. If I need any help they help me in a nice way and the staff say we're here to help you". There was sufficient and suitable staff to meet people's needs. Staff knew who to report concerns to if they were worried about people's wellbeing. Infection control was maintained.

People's needs were assessed and reviewed on an on-going basis. People were supported to maintain their health. They received support from external healthcare professionals when required. People received appropriate end of life care to ensure their comfort.

People told us that they enjoyed the food. Comments included, "The food is nice. The meals are lovely". People's had access to nutrition and hydration to meet their needs. Communal areas, as well as private spaces, enabled people to spend time on their own or with others.

People and relatives were involved in decisions related to the running of the home. They could make complaints and knew how to do this. People told us that they were content living at the home and spoke with fondness about some of the staff that supported them. One person told us, "The staff are very nice and I class them as my friends". People's privacy and dignity was maintained.

The overall rating for this home is Requires Improvement. This is the second time that the home has been rated as Requires Improvement. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 home was not consistently safe.

Not all people had access to medicines when they required them.

Not all risks to people's safety had been considered, identified or mitigated.

There were sufficient staff to ensure people's needs were met.

People were protected from the spread of infection.

Is the service effective?

Requires Improvement ●

The home was not consistently effective.

The provider had not always assessed people's capacity when making specific decisions.

Staff had the necessary skills to meet people's needs.

People's needs had been assessed. They were supported to maintain their health and their healthcare needs were met.

People had enough to eat and drink. They were complimentary about the food.

Is the service caring?

Good ●

The home was caring.

Staff and management were kind and caring.

People were involved in their care.

People were treated with respect; their privacy and dignity was maintained.

People could continue to be independent.

Is the service responsive?

Requires Improvement ●

The home was not consistently responsive.

People did not always receive their medicines in a person-centred way.

Information and resources were not always adapted to meet people's communication needs.

People were supported to engage in activities, interaction and stimulation to meet their social needs.

People and their relatives were made aware of their right to complain.

People could plan for their end of life care.

Is the service well-led?

The home was not consistently well-led.

There was a failure to continually improve the service.

Quality assurance processes were not always effective.

Feedback from staff about the leadership and management was not positive.

The registered manager worked in partnership with people, their relatives and external healthcare professionals.

Requires Improvement ●

Forest View

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 26 November 2018. The inspection team consisted of two inspectors and two experts-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. In this case the experts-by-experience had experience of older people's services.

Before this inspection we looked at information we held, as well as feedback we had received about the home. We communicated with Healthwatch. Healthwatch are an independent national champion for people who use health and social care services. They visit homes to obtain people's views on the service they receive. The home had recently had a visit from Healthwatch and we contacted them to gain their feedback. We also looked at notifications that the provider had sent us. A notification is information about important events which the provider is required to tell us about by law. Due to technical problems on our part, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with 26 people, five relatives, five members of staff, the registered manager and the operations manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for eleven people, three staff records, quality assurance audits, incident reports and records relating to the management of the home. 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 observed the care and support people received as well as the lunchtime experience and the administration of medicines.

Is the service safe?

Our findings

People and their relatives told us that people were safe. One person told us, "It's safe, if I need any help they help me in a nice way and the staff say we're here to help you". Another person told us, "If I use the call bell they come quite quickly. They come in every two hours at night to see if I'm alright. And if I ring for the bathroom they come at night. I don't think they can improve anything". Despite these positive comments, we found an area of practice that required improvement.

Medicines were not always managed safely. People were supported to take their medicines by trained staff who had their competence assessed. Staff were respectful when administering medicines and involved people in the process, explaining their actions and respecting people's wishes when they refused medicines. There were clear guidelines for staff to follow, as well as information that could be passed to other healthcare professionals, such as when a person had to go to hospital. Guidance identified people's needs and preferences and informed staff of how to administer people's medicines. However, people did not always receive their medicines as intended.

Three people were living with Parkinson's disease. Medicines had been prescribed to help manage their condition and associated symptoms. Parkinson's UK recognise the importance of medicine optimisation for people living with Parkinson's disease. It states that getting Parkinson's medication on time is essential for symptom management. Guidance for the person's medicines advised, 'Try to take the medicine at the same time each day. Do not change the times at which you take your tablets'. Medicine administration records (MAR) showed that all three people had been given their Parkinson's medicines outside of prescribing guidelines.

Records for one person stated, 'To support to take medication so that they are taking the right dose at the right time to ensure that their health is not compromised'. MARs for the person showed that they had consistently been given their medicines later than the prescribed times. When this had occurred, they had not always had access to all their doses of medicines. As medicines had been given later than the prescribed times, staff had had to adjust the scheduling of the other doses of medicine. This ensured that there were sufficient time in-between doses. By doing this, however, the person had sometimes missed their final dose of medicine.

Records for another person showed they were prescribed their Parkinson's medicines via a trans-dermal patch that needed to be applied to their skin each day. MARs for the person showed that this had been administered each day, however, because the medicine was not given at the same time each day the person had sometimes gone without their trans-dermal patch being changed for over 24 hours. There was a risk that because people did not receive their Parkinson's medicines according to the prescribing guidelines, that the symptoms of their condition were not well-managed. The ineffective management of these people's medicines may have increased the risk of their condition not being well-managed.

People who were at high-risk of choking had been assessed. Thickeners had been prescribed to thicken people's drinks to minimise the chances of them choking. On 6 February 2015, NHS England issued a patient

safety alert on the risk of death by asphyxiation by accidental ingestion of fluid or food thickening powder. It advised the safe storage of thickeners to reduce the risks of this occurring. Thickeners that were used for one person were not stored securely. This did not ensure that people's access to thickeners was limited and did not minimise the risk of harm. When this was fed back to the registered manager, they acknowledged that this was not good practice and advised that the thickener would be stored securely immediately.

Most chemicals, that had the potential to cause people harm if ingested, were stored securely. Observations, however, showed that a sluice room which contained cleaning products was left unlocked. This meant that people could have accessed the chemicals which could have caused them harm. This was fed back to the registered manager who immediately locked the sluice room door.

The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of people receiving care and treatment. They had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had necessary checks completed to assure the provider that they were suitable to work with people. Appropriate pre-employment checks with the Disclosure and Barring Service (DBS) had been made before staff started work. The DBS aids employers in making safer recruitment decisions and helps ensure that unsuitable people do not work with vulnerable groups. Staff's employment history and references from former employers were also gained. People had access to sufficient staff to meet their needs. They told us that when they called for assistance staff responded promptly. Observations confirmed this. Consideration of staff's skills and levels of experience were made. New staff were allocated to work alongside existing staff to ensure that they were supported to have a good awareness of people's needs. The allocation and deployment of staff meant that there were staff within communal areas if people required assistance.

Staff had a good understanding of their responsibilities to safeguard people from harm. They understood the signs and symptoms that might indicate someone was at risk of harm. They were aware of who to report their concerns to, to ensure people's safety. When there were concerns about people's safety, appropriate referrals had been made to the local authority. Advice and guidance provided by the local authority had been listened to and complied with. People felt comfortable to speak to staff if they had concerns about their care.

Staff were aware of and anticipated people's needs. Some people were living with dementia. One person demonstrated signs of apparent anxiety or distress. Staff supported them appropriately, they used distraction techniques and interacted with the person, to minimise the person's anxiety and diffuse potentially challenging situations. The person was reassured and visibly calmer following their interaction with staff.

Risk assessments, which included people's mobility and nutrition, as well as lifestyle choices that they chose to pursue, were assessed and regularly reviewed. Staff worked as a team and shared information to ensure that staff were aware of the risks to people's safety and knew how to support people appropriately.

Accidents and incidents that had occurred had been recorded, monitored and analysed to identify trends. Lessons were learned and information from the analysis of accidents was used to inform staff's practice and supporting documentation. For example, risk assessments and care plans were updated to reflect the change in people's needs following an accident.

People had access to equipment that was regularly checked to ensure their safety. Infection control was

maintained and the home was clean. Staff used personal protective equipment when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination.

Is the service effective?

Our findings

People were involved in decisions that affected their day-to-day care. They told us that staff respected their wishes and that they were provided with choice. We found an area of practice, however, that needed improvement.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home 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. For people who were unable to consent to living at the home, DoLS applications had been made to the local authority. When DoLS had been authorised, staff had worked in accordance with any conditions that had been associated to them.

The provider and staff had not always worked in accordance with the MCA to ensure that people's capacity was assessed when making specific decisions. Two people used bed rails. Bed rails can be implemented to support people's safety but can be seen as a form of restraint. One person's relative had been asked for their consent. However, staff had not considered the person's own ability to consent to the use of these themselves.

Relative's had been sent a letter asking, 'I write to ask you if you wish your relative to receive the annual flu vaccination. Please could you advise us as soon as possible'. Although this was proposed to ensure that people maintained good health, staff had not considered people's own ability to consent to this. Relatives did not always have a Lasting Power of Attorney (LPA) to legally be the sole decision-maker for these decisions. When staff were asked how decisions were made for people who were living with dementia, they explained that their family would be asked to give consent. Staff did not understand the steps that needed to be considered before this occurred. For example, formally assessing people's capacity in relation to specific decisions and ensuring that only people who had a legal right to make decisions on people's behalfs were the sole decision-makers. The provider's and staff's understanding about MCA is an area of practice that needs improvement.

People's physical and emotional health had been assessed and staff worked hard to ensure that people were supported to meet their needs. People told us that they had regular access to a GP and had confidence that staff would seek medical assistance if they became unwell. Staff were responsive when there were changes to people's health. Timely referrals to external healthcare professionals ensured that people were provided with appropriate treatment and coordinated care. People's skin integrity and their risk of

developing pressure wounds was assessed. For people who had wounds, regular monitoring took place and appropriate treatment provided by community nurses. Equipment to relieve pressure to people's skin, such as specialist cushions and air mattresses were used, as well as support from staff to reposition.

People were reassured by staff's abilities. Staff were supported and encouraged to undertake courses that the provider felt were essential to their roles. Observations of interactions between people and staff demonstrated that staff were mindful of how best to interact and engage with people who were living with dementia. Links with external healthcare professionals enabled staff to have access to current good practice and to develop within their roles. Staff had access to supervision and appraisal meetings.

People and their relatives told us that they were happy with the environment. People had access to communal areas so that they could spend time with others. Communal areas were light, bright and spacious and enabled people to mobilise from one area of the home to another. Small kitchenettes enabled people to have access to drinks and snacks that were prepared by staff. When people preferred to spend time on their own, quieter spaces, as well as their own rooms, provided people with privacy. People could personalise their bedrooms with furniture and ornaments that were important to them. Observations showed that people did not have a problem navigating or orientating themselves around the home. The provider was in the process of improving the environment so that people who were living with dementia, were provided with visual prompts to inform them which room was theirs and to support them to orientate around the building. New signs for people's doors, which could contain a photograph of them or a picture that was important to them, had been purchased.

People told us that they enjoyed the food. Comments included, "I had my favourite yesterday, prawn cocktail. The food is excellent. They will find me something else if I don't like it" and "The food here is nice. The meals are lovely". People had access to drinks and snacks throughout the day and observations showed staff considered people's nutrition and hydration needs. For example, one person, who had been supported by staff to eat their meal, had refused to eat. Staff had respected this and had made the person a milkshake to increase their calorie intake. Most people chose to eat in the main communal dining areas. Tables were laid with tablecloths, placemats and cutlery and people had a choice of drink to accompany their meals. Staff were attentive and ensured that people had sufficient quantities to eat and drink.

People's diversity was recognised. When people's needs had been assessed, they had been asked if they had any religious or cultural needs. People had access to regular visits from religious leaders if they wished to continue practising their faith.

When people had specific healthcare conditions, such as diabetes, they were supported, like others, to follow a healthy diet. As well as this, staff ensured that they made cakes and desserts with sugar replacement products so that people could still enjoy eating things that were sweet. Other healthcare conditions, such as when someone required a gluten-free diet, were respected. People had access to foods that met their needs. For people who were living with dementia, efforts had been made to encourage eating by offering some people with finger foods. This enabled people to be independent when eating.

Is the service caring?

Our findings

People and relatives spoke fondly of the staff. Comments from people included, "People are very friendly and kind. I like it here", "These girls are first class" and "The staff are very nice and I class them as my friends". One person was overheard telling a member of staff, "You're not a worker you're my friend".

The home had a friendly and welcoming atmosphere. Staff knew people well and took time to have conversations with them. Staff were considerate and caring in their approach. People's privacy was respected. Staff were mindful of the need to support people sensitively when assisting them with intimate tasks such as their personal care needs. People told us that staff ensured that their privacy and dignity was maintained. Staff knocked on doors and waited for an answer before entering people's rooms. They spoke discreetly to people and with other staff about people's needs, to ensure that other people did not overhear. People had been asked about their preferences with regards to the gender of staff and told us that this was respected. People's privacy, with regards to information that was held about them, was maintained. People's care plans were stored in locked offices and conversations about people's care were held in private rooms.

People's diversity was respected and people were treated as individuals. Staff adapted their approach to meet people's needs and preferences. People's personal and ethical choices were known and respected. For example, when people chose to follow a vegetarian diet, staff respected their choice. People's identity was maintained and they wore clothes of their choice.

Staff were caring and attentive when people displayed signs of distress or anxiety. They took time to offer gentle reassurance and answer people's questions. Staff were patient and kind when people, who were living with dementia, had forgotten that they had been informed of a topic. Staff interacted with the person as if hearing the question for the first time. Staff's interactions appeared to calm and reassure people who smiled and looked reassured after speaking to staff.

People and their relatives could express their needs and wishes. They had contributed to the development of care plans and records showed that they, or their relatives, had continually been involved in discussions relating to their care. Residents' and relatives' meetings enabled people to be kept informed of what was happening at the home. People and their relatives could also share their views and provide their feedback to staff. Surveys were sent to people and their relatives to gain their feedback so that the provider was aware of their experiences. People could have access to advocacy services if they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

People's independence was promoted. People were supported to continue to do as much as they could for themselves, with staff offering support when needed. Observations showed people independently mobilising between different areas of the home and choosing how they spent their time.

People could maintain relationships with those that were important to them. It was apparent that positive

relationships had developed between some people and staff. People had access to telephones so that they could contact family and friends. Relatives and visitors could visit their loved one at any time and told us that they were made to feel welcome. A relative told us, "I can visit at any time and I often talk to other residents and visitors so it is a nice atmosphere. The staff are very kind and very caring".

One person had recently passed away. Staff were overheard talking about the person and had planned to attend their funeral to say their goodbyes. This demonstrated that staff cared about the people that they supported.

Is the service responsive?

Our findings

At the previous inspection on 30 and 31 October 2017, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns about the lack of person-centred care to meet people's individual needs. It was not evident how people were supported to enjoy activities and pastimes that were meaningful to them. People and their relatives had not been involved in on-going discussions relating to people's care. At this inspection, it was apparent that improvements had been made and the provider was no longer in breach of this Regulation. We did, however, find areas of practice that needed improvement.

The registered manager had written to people's relatives inviting them to regular meetings or conversations about people's care needs. Records showed that people, or their relatives, had been part of discussions to ensure that they were provided with the opportunity to contribute to decisions that affected people's lives as well as the care provided. People's care was reviewed at regular intervals to ensure that the guidance provided to staff was up-to-date and met people's current needs.

People had access to meaningful stimulation and pastimes to occupy their time. Information about people's lives before they moved into the home had been collated. This provided staff with an insight into people's lives and helped staff and people to develop relationships. Staff knew people well. The provider had employed two members of staff who provided activities. People had access to a range of group activities and told us that they enjoyed participating in these. Comments from people included, "I like the dancing and the music" and "The musical entertainment is smashing". A relative told us about a remembrance service that had been held, they told us, "Staff came in for the service on their days off. It was very rewarding and the staff were excellent. I watch body language and the staff were all keen to be there. Poppies were dropped from above. Excellent".

Observations showed people reading newspapers, watching television or playing cards with one another. Radio stations were tuned into the television which provided music for people to enjoy. Staff ensured people with differing needs, such as when they were living with dementia, had access to stimulation that they would find engaging. For example, Dementia UK states, 'The use of dolls can bring great benefit to some people with a diagnosis of dementia, particularly those in later stages. It involves making a doll available to the person to hold or to sit with'. Observations of one person showed that they had access to a doll. The person could be seen being attentive and caring towards the doll and staff interacted with them about their 'baby'. The person welcomed this and smiled when staff interacted with them.

People were encouraged and supported to maintain and develop relationships and avoid becoming socially isolated. A relative told us, "I can't fault the home. It's good, it's improved my relative from when they were living on their own and having a carer coming in. A very positive move. They are definitely very happy here. They have never been a very sociable person but since they've been here they've been very sociable. They've made friends here. It's taken a great weight off our shoulders".

Three people were living with Parkinson's disease. The provider had not ensured that they supported these

people in a person-centred way and they were not always responsive to their individual needs. The administering of their medicines was service-led. People had not always had access to medicines as intended or at the prescribed times. This was because the prescribing times had not always aligned with the routines of the home. More information about this can be found within the Safe section of the inspection report.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 25 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Staff had not always ensured that people's communication needs were documented in their care plans. It was not always evident that staff had considered the impact of people's sensory impairments or conditions on their care, or the effect it might have on their ability to access information in a way that they understood.

Observations showed that people had access to larger playing cards. This enabled people to hold the cards more easily if they experienced difficulties with their dexterity. It also enabled people to see the numbers and suits more easily. Not all information or resources, however, were adapted to enable people to have access to them. One person told us that they enjoyed playing Bingo yet struggled to see the numbers on the Bingo cards. They told us, "I like playing Bingo. I can't see the numbers very well on the card". When this was fed back to the provider they told us that the person received support from staff to enable them to participate.

Although people were complimentary about the food, when people were living with dementia, the provider had not always considered their needs and levels of understanding in relation to information that was provided to them. People were asked for their meal choices the day before having them. Some people told us that when choosing this, they often forgot what they had chosen. Some units within the home had the menu of the day written on blackboards, however, others did not. The Social Care Institute for Excellence advises, 'As dementia progresses a person may have difficulty choosing and deciding on the food they want to eat. Avoid asking a person with dementia to choose a meal in advance. Simply calling out a list of options can be confusing and difficult for the person to understand as they may no longer recognise what the food is from hearing the words alone and may struggle to remember all the options given to them'. It suggests offering visual prompts such as photographs of food or plating-up food to show people to aid their choice.

We recommend that the provider seeks advice from a reputable source in relation to providing information for people to meet their communication needs

People were provided with a call bell so that they could call for assistance from staff. For people who were unable to use a call bell, due to their capacity and understanding, pressure mats were used so that when people mobilised staff were alerted and could go to people's aid. Regular checks were also undertaken when people were in their rooms to ensure their needs were responded to in a timely manner.

People were made aware of their right to complain. Residents' and relatives' meetings, as well as surveys, provided opportunities for people and their relatives to share their opinions. People told us and records confirmed, that people could speak freely and air their views. People told us that they were happy with the care they received and would feel comfortable raising concerns. When people or their relatives had done this, records showed that the provider had taken appropriate and timely action to deal with these.

People were provided with the opportunity to plan for their end of life care. People had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. Some people did not want to discuss this and staff had respected their wishes.

Is the service well-led?

Our findings

At the previous inspection on 30 and 31 October 2017 there was a lack of oversight. Quality assurance processes had not identified the shortfalls that were found at the inspection. At this inspection, we continue to have concerns about the registered manager's and provider's overall ability to continually improve the service provided. We found an area of practice that required improvement.

The management team consisted of the registered manager and team leaders. An operations manager regularly visited the home to conduct quality assurance audits and to support the registered manager. The registered manager, operations manager and the provider's quality assurance team undertook regular audits. These provided opportunities to monitor the systems and processes within the home to help ensure they were effective. Results of the most recent audit, conducted by the provider's quality assurance team, had scored the home 91%. Shortfalls that were found at this inspection had not been identified within the audits that had been conducted. The inability to identify the concerns that were found at this inspection, raised concerns about the effectiveness of the quality assurance systems used by the provider.

People who had Parkinson's disease did not always have access to their medicines in a way that they had been prescribed. This meant that there was a risk that their health condition was not well-managed. Products, such as thickeners for people's drinks and cleaning products, that had the potential to cause people harm, had not been securely stored. People's capacity had not always been assessed in relation to specific decisions relating to their care. People's relatives, who did not have the legal authority to be sole-decision makers, had made decisions on people's behalves. People did not always have information and resources provided to enable them to meet their communication needs.

There are concerns about the provider's oversight and overall ability to maintain standards, to continually improve the quality of care and embed learning from their other services. There has been reoccurring themes throughout the provider's other services in relation to MCA as well as medicines management for people who were living with Parkinson's disease. During inspections of the provider's services it has been identified that there is a lack of understanding about MCA. This has now been identified in nine of the provider's services in the Sussex area. There has also been insufficient oversight to ensure that when people have Parkinson's disease, their medicines are managed to ensure that they receive them in a timely way. This has now been identified in five of the provider's other services in the Sussex area. This has raised concerns over the provider's ability to have clear oversight across their services within the Sussex area.

Feedback, in relation to the leadership and management of the home was not always positive. People had been informed of who the registered manager was within the documentation provided to them when they first moved into the home. The registered manager's registration with CQC was also on display. However, despite this, people and their relatives were not always clear who the registered manager was. Some staff told us that there was low staff morale, that they felt devalued and unsupported by both the registered manager and the provider. One member of staff's practice demonstrated a feeling of discontent with them openly discussing their unhappiness about the management and systems within the home in front of people. Some staff we spoke to were unhappy with the management of the home and felt that the

registered manager and provider were unapproachable and that they only felt supported by their immediate team leaders. Some staff felt that the registered manager did not have a visible presence within the home and did not take time to see people, their relatives or staff.

Some staff told us that they lacked confidence in the registered manager's or provider's ability to act when issues were reported to them. Some staff were unhappy with the apparent lack of equipment and resources to enable them to carry out their roles. However, when this was fed back to the registered manager plans had already been made to order items that were broken or required repair. Three members of staff told us that they had consistently fed back to the registered manager that the keys to the sluice rooms were missing for several months and could therefore not be secured. They told us that despite this no action had been taken. Observations found that sluice rooms were unlocked and on one occasion one had contained cleaning products that had the potential to cause people harm. Records showed that staff meetings had taken place. Staff had been able to share their views and concerns. Feedback from staff about the action taken in response to their suggestions, was not positive. A member of staff told us, "Some things are brought up but nothing gets done".

Records, to provide guidance to staff and to document the care people had received were not always sufficient or consistently maintained. Records were not always completed in their entirety and these incomplete records made it difficult to ascertain if people had received appropriate care or if staff had failed to complete the required records. Insufficient guidance in one person's care records did not provide staff with the necessary information to inform their practice. The person was assessed as being at risk of developing pressure wounds. They had access to pressure-relieving equipment and community nursing teams to maintain their health. There were concerns, however, that information about the frequency in which the person should be supported to reposition was not sufficient. Records to document the frequency of repositioning raised concerns about how often the person was being supported to change position. When records of people's care were not monitored there was a potential risk that any changes in people's conditions may not have been recognised. Records of people's fluid intake was required to be tallied throughout the day. This helped ensure that the person was receiving sufficient amounts of fluid. Records for some people showed that this had not occurred. Although there were no concerns about the amount of fluids they had consumed, by not totalling their fluids there was a lack of oversight to assure the registered manager that people were receiving appropriate amounts to maintain their hydration. Records showed that the completion of records had been raised by the registered manager within staff meetings; however, it was not evident that improvements had been made.

The provider had not ensured that they assessed, monitored or improved the quality and safety of the services. Neither had they mitigated risks relating to the health, safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had developed a 'Future leaders' programme. The registered manager and staff had undertaken exercises to help improve people's experiences such as making suggestions about the improvement of the external building and people's own rooms. Staff had been involved in these discussions and there were plans on how the suggested ideas would be implemented.

The provider had complied with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

People and their relatives told us and records confirmed, that the registered manager and provider demonstrated their awareness of the duty of candour CQC regulation. The intention of this regulation is to

ensure that providers are open and transparent with people who use services and other 'relevant persons'. Relatives told us that they were informed if there were any changes to their loved one's care. The provider had also displayed the rating from their last inspection to inform people and relatives.

People and their relatives had been invited to be involved in decisions that affected the home. Regular residents' and relatives' meetings ensured that people could air their views and discuss any ideas or suggestions. Regular surveys were sent to gain further feedback.

Links with external healthcare professionals and local authorities had been developed to ensure that people received a coordinated approach to their care and staff learned from other sources of expertise. The registered manager had communicated with the local Dementia Alliance and there were plans to start to engage more with the local community who were hoping to create a 'Dementia Friendly' town.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment.</p> <p>The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users. They had not ensured the proper and safe management of medicines.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.</p> <p>The registered person had not ensured that systems and processes were established and operated effectively to:</p> <p>Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).</p> <p>Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise</p>

from the carrying on of the regulated activity.