SHC Rapkyns Group Limited

Forest Lodge

Inspection report

Horney Common
Nutley
Uckfield
East Sussex
TN22 4EA

Tel: 01825712514
Website: www.sussexhealthcare.org

Date of inspection visit:
08 May 2019
09 May 2019

Date of publication:
23 October 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Forest Lodge is a residential care home that provides personal and nursing care to people aged 65 and over and people with dementia. At the time of the inspection 54 people were using the service.

Forest Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. This does not include Forest Lodge but the investigation is on-going and no conclusions have yet been reached.

People's experience of using this service:

Risks to people were not always assessed, monitored and managed safely.

People were not always kept safe from risk of abuse.

Medicines were not always managed safely.

There were not always enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.

Adequate cleaning to combat odours caused by incontinence was not taking place.

Lessons were not always learnt and improvements made when things had gone wrong at the service.

People and those acting lawfully on their behalf had not always given consent before being provided with support.

Conditions on authorisations to deprive a person of their liberty were not always being met appropriately.

People's needs and choices were not always assessed so staff did not always know or understand how to deliver support for them to achieve effective outcomes.

People did not always receive personalised care that was responsive to their individual needs, including support with meaningful activities within the service and the wider community.

Information about people's care and treatment was not always made available in the most accessible way for people.

Quality assurance and governance systems were not operating effectively. Staff and management were not

supported to understand or fulfil their responsibilities and ensure that quality performance and risks were understood and managed.

There were safe recruitment practices.

Staff had regular training, updates and supervisions.

People and their relatives told us staff were kind and caring, listened to them and respected their choices.

People were encouraged to be involved in their day to day care and be as independent as possible.

Complaints were managed and responded to appropriately.

We have recommended that the provider seeks advice and considers how to improve the design and adaptation of the home and outside spaces, to better meet the needs of people and promote the independence of people.

This inspection identified continued breaches of Regulations 9, 12, 15, 17, 18 and breaches of regulation 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rating at last inspection: We last inspected Forest Lodge on 23 and 24 May 2018. The report was published in August 2018 and then re-published to include information about enforcement action on 24 January 2019. The service was rated Requires Improvement.

Why we inspected: This inspection took place on 8 and 9 May 2019 and was a scheduled and planned inspection based on the previous rating.

Enforcement: We imposed conditions on the provider's registration, due to repeated and significant concerns about the quality and safety of care at several services they operate. The conditions are therefore imposed at each service operated by the provider, including Forest Lodge.

The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up: The overall rating for this service is inadequate. This means the service has been placed in Special Measures. Services in special measures are kept under review and inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. Services in Special Measures will be kept under review and, if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling or varying the terms of their registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Forest Lodge

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

This inspection took place over two days on 8 and 9 May 2019.

The inspection team on 8 May consisted of two inspectors, a nurse specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. For this inspection the expert by experience's specific area of expertise was dementia care.

The inspection team on 9 May consisted of two inspectors.

Service and service type:

Forest Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

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

Notice of inspection:

This inspection was unannounced.

What we did:

Prior to the inspection we reviewed information we held about the service. We considered the information which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals.

We looked at any safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

During the inspection we spoke with three care staff and two activities staff, four registered nurses, the chef and the regional operations manager.

We spoke with a visiting health and social care professional who was engaged in on-going work with the provider regarding people who used the service.

We 'pathway tracked' three people using the service. This is where we looked at people's care documentation in depth and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We spoke with 6 people using the service and 5 people's relatives and observed people's support across all areas of the service.

We reviewed staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records.

We also reviewed quality audits, policies and procedures, staff rotas and information about activities people were supported with and provided by the service.

The registered manager was on extended leave during the site visits of 8 and 9 May. We arranged to speak with them after the inspection via telephone and did this on 16 May.

For this inspection we requested a Provider Information Return (PIR). 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.

This inspection took place before the deadline for the PIR had expired. We received the PIR as expected and reviewed this after the inspection site visits had taken place.

Inadequate

Is the service safe?

Our findings

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

- Some aspects of the service were not always safe and there was limited assurance about safety.
- People were at risk of avoidable harm.
- Some regulations had not been met.

Systems and processes to safeguard people from the risk of abuse

●People were not protected from the risks of inappropriate restraint. One person's behaviour care plan identified they may become physically aggressive towards other service users and staff. Their plan contained directions that it may be necessary for up the three staff to physically hold the person's shoulder and hands and re-direct the person if this happened. Staff had not received behaviours that may challenge training that included safe physical re-direction or restraint techniques. There was no reference or specific direction in the person's care plan about how to hold and re-direct the person as safely as possible. This created the risk that the person may be held in an unsafe or harmful way; which could be deemed to be abusive.

● The person's behavioural monitoring charts for April 2019 noted three incidents where the person had physically assaulted staff. One staff member told us there had been repeated incidents since the last inspection where the person had physically assaulted staff. They showed us recent injuries that they said had been sustained while supporting the person. Staff monitoring records of these instances contained minimal detail of how they had supported the person when they displayed these behaviours. Management and registered nurse reviews of these incidents did not confirm if the person had or had not been supported safely or in the least restrictive manner.

●We received a mixed response from staff when asked how they reacted to the person becoming physically aggressive. Some staff said they would rely on distraction techniques alone and they had not used physical interventions. Other staff who regularly worked with the person said they and other staff had followed directions in the care plan and used unspecified "holds" to re-direct and "sit them down" when they became challenging. The person's challenging behaviour care plan had been reviewed regularly, with a recent review in April 2019 recording that the person was still displaying these physically aggressive behaviours and that staff should "continue with same care plan". This meant the person was at continued risk of unnecessary or unsafe control or restraint and improper treatment.

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

●In response to us bringing this concern to their attention, management provided information during and after the inspection about immediate actions they were taking to make sure that the person was being supported as safely as possible.

●People we spoke with told us that they felt safe. Staff and management were aware of a process to follow to report safeguarding concerns internally and externally. Staff had received safeguarding training. This training was designed to aid staff understanding of signs of abuse, including discriminatory abuse, what these signs might look like and why it was important staff acted if they recognised any concerns.

Assessing risk, safety monitoring and management, learning lessons when things go wrong, using medicines safely, staffing and recruitment

● At the last inspection we identified that the provider was not doing all that was reasonably practicable to mitigate risks to people whose behaviour may challenge which did not include inappropriate restraint. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we looked to see if the provider had made necessary improvements since the last inspection and if this breach of regulations had been met and found that it had not.

● Some people living at Forest Lodge displayed behaviours that may challenge and required support to manage risks of harm to themselves and others. People had several different risks assessments and care plans containing guidance such as distraction techniques, and monitoring and review of behavioural incidents, to help keep people safe.

●However, information and detail in people's different challenging behaviour risk assessment and care plans was not always consistent or contained enough detail. Actions for staff to follow that had been identified in these documents had not always been considered in line with best practice guidance. This increased the risk that staff would not know how or be able to meet people's needs and manage risks associated with their challenging behaviours safely.

● Where incidents of challenging behaviour had occurred, staff were not always using monitoring and recording systems effectively, so it was not evident that people had been supported safely. Records did not show that internal reviews had always taken place after incidents had occurred to see if risks were being managed appropriately. Information about people's challenging behaviour needs and support was not always shared regularly or in a timely manner for further external review with health or social care professionals to understand, prevent and manage risks.

●For example, one person's challenging behaviour care plans identified some distraction methods to use when the person displayed challenging behaviours. However, information to help staff understand the root cause of the behaviours and best practice methods to help prevent, as well as react to, this person's challenging behaviours occurring had not been identified.

●The person had regular prolonged periods of challenging behaviour. There were a lack of timely internal reviews or referrals being made to external professionals to help make sure the person had the best support to prevent and manage the risks related to their behaviours that may challenge. This left the person at increased risk of on-going harm and distress and an on-going reduction in their quality of life.

●In response to us bringing this concern to their attention, management provided information during and after the inspection about immediate actions they were taking to make sure that the person was being supported as safely as possible.

● Many people living at Forest Lodge had been identified as being at risk of choking when eating or drinking. Staff had arranged for additional support from specialist community speech and language therapist (SaLT)

teams to help assess and provide guidance about how to manage these eating and drinking risks. However, staff were not always aware or following this guidance, leaving people at risk of harm. For example, one person required constant supervision and their food to be fork mashed and cut into small pieces. We saw staff give the person a whole sandwich and leave them to eat this unsupported.

● Most of the 54 people living at Forest Lodge had a choking risk assessment that identified the possible need to for staff to use a de-choker device to prevent serious injury or death in the event of a choking incident. Although there were two de-choker devices situated in the service, staff we spoke told us there were only one. Not all staff had been trained to use this device and staff we spoke with did not always know where the device was located. This left people at risk of not receiving an assessed emergency intervention in the event of a choking incident occurring.

●Risks associated with choking have been highlighted in inspection reports about a number of the provider's other services. This information had not led to similar risks to people at Forest Lodge being properly reduced.

●In response to us bringing this concern to their attention, staff at the service took immediate action to reduce this risk.

● Many people at Forest Lodge required support to manage risks associated with their mobility and manual handling support needs, including risks of falls. Staff had supported people to receive additional support from specialist internal and external physiotherapists and community falls teams to help assess and provide guidance about how to support people as safely as possible. However, staff were not always following this guidance or able to demonstrate that they understood how to prevent and manage these risks.

● For example, we observed staff remove a person's mobility equipment when they temporarily stopped moving, rather than recognising this behaviour as part of their health condition and attempting to offer cues for them to continue. This left the person at risk of falling as they may have not been expecting their mobility aid to be removed.

●One person required support to get up and start walking safely and their risk assessment included directions that staff should keep them under close observation to be able to offer this support if needed. The person was seen attempting to get up more than once unsupervised, whilst very unsteady on their feet. We saw people who required footplates on their wheelchairs being supported without the plates in use. This left people at risk of harm from falling or injuring themselves.

●In response to us bringing these concerns to their attention, staff at the service took immediate action to reduce this risk.

● People had assessments in place detailing the level of support they needed to take their medicines safely. Medicines were stored safely and securely. Registered nurses were responsible for administration and had received training to do this. There were systems for recording, ordering and disposal of medicines. However, we found that these systems and processes had failed to ensure medicines were always being managed safely and properly.

● People did not always have accurate, up to date or detailed protocols for when to offer and administer any prescribed 'as and when required' (PRN) medicines. Medication Administration Records (MAR) had not always been completed to record when PRN medicines had been given and the reasons why. This increased

the risk that people may have too much or too little PRN medicines or that they may be administered where it was not necessary.

● MAR had not always been completed accurately to record when medicines had or had not been administered. For example, there were gaps in administration records where staff had not signed, so it was not known if people had received their medicines. MAR's showed some people refusing or spitting out their medicines but did not record actions taken in response. This increased the risk that people may not be receiving their medicines as intended.

● Staff completed stock control sheets after administering medicines to keep a total of how much medicine people had. For some people, staff had recorded on stock control sheets that they had administered more medicines than people had been prescribed, although the MAR had been signed to say they had received the intended doses. People had not received their medicines due to errors in re-ordering stock. There were daily, weekly and monthly medicine audits by registered nurses (RGNs) and the manager, but these had failed to consistently identify, investigate and address PRN, MAR and medicine stock issues. This placed people at risk of avoidable harm.

●We observed RGNs administering medicines. For the Beech unit of the service, there were no handwashing facilities available in the medicine storage and preparation room. RGNs had to prepare before administering medicines to people by washing their hands in the service users water sink in the communal lounge. This presented and created a risk of cross-infection for people and staff.

●The service was currently using some agency staff to ensure shifts were covered while they recruited to staff vacancies. Agency staff received a basic induction that covered safety related environmental, accident and incident and emergency recording and reporting systems, processes and practices.

●Agency RGNs we spoke with on 8 and 9 May raised concerns over the basic nature of their induction. On 9 May, one of agency RGN's said their induction had not been formally completed that morning and they had not been given time to access and discuss information about how to support people's individual needs safely before assuming control of leading the shift. This had meant they were relying exclusively on speaking with other staff or locating documents themselves if needing information. This could increase the risk that there might be an undue delay in providing people with support they needed to keep them safe.

●The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We saw that all other agency staff who worked at the service had been supported to formally complete inductions. We discussed this incident with the provider who advised they would review the circumstances to help ensure that that the failure to follow the complete formal induction process was not repeated.

●Rotas had been written to allocate staff, based on the provider's calculations of the levels of support people needed. People told us they thought there were enough staff available to meet their needs and support them to stay safe. One person said, "The staff are here 24 hours a day. There are enough staff". Another person said, "Carers come pretty quickly if I press my buzzer". Staff told us although they could be busy at times, they felt staffing levels were safe.

●We observed that in most instances, people received support without waiting too long. We have commented more on staff deployment, including delays to people being supported, in the Effective and Responsive sections of this report.

● All staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Permanent staff submitted applications, references and passed a competency-based interview prior to being offered a position.

● All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Preventing and controlling infection

● At the last inspection we identified that the provider had not acted to ensure adequate cleaning took place to combat odours caused by incontinence. There was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent us a plan telling us the actions they were taking to address this issue. At this inspection we looked to see if the provider had made necessary improvements since the last inspection and if this breach of regulations had been met and found that it had not.

● Actions the provider had told us they would be taking to address the issue such as environmental spot checks, audits, reporting issues to domestic staff and regular cleaning by separate cleaning staff were taking place. However, these actions had not been effective in preventing offensive and unpleasant odours in the premises.

● On the first day of the inspection, all members of the inspection team noticed offensive odours which appeared to be caused by urinary incontinence in the communal lounge and in some corridors in parts of the service where people's bedrooms were. A relative we spoke with told us that they regularly noticed these odours in the premises and they also occasionally noticed odours caused by faeces. Another relative told us they also noticed these odours. They said, "the smell can be awful".

●The provider had failed to ensure adequate cleaning took place to combat odours caused by incontinence. This is a repeated breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed this with the registered manager and the regional operations manager. They confirmed that an action they had told us they would take to replace carpets had not yet been completed. In response to our raising concerns, cleaning staff were asked to ensure deep cleans were taking place more frequently until suitable replacement flooring was provided. All staff were also being reminded of their responsibilities to report all odours immediately, so areas could be cleaned when required.

● On the second day of the inspection we saw deep cleaning had taken place and did not notice any more odours in the communal lounge, although odours remained in some corridors.

● Plastic gloves and aprons were available and staff used these when supporting people with their personal

care. Hazardous waste was managed appropriately. There were separate catering staff and both they and support workers received food hygiene training to help ensure food was handled and prepared safely.

Requires Improvement

Is the service effective?

Our findings

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

●The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

●Regulations may or may not have been met.

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 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 service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●Where people might require a DoLS there was a record of an appropriate assessment process and the registered manager had submitted applications for DoLS for people. However, where DoLS had been authorised, relevant DoLS conditions were not always clearly identified. Staff were not always aware of where people had authorised DoLS conditions and it was not always evident conditions were always being met. This increased the risk that restrictive practices were occurring that were not proportionate or in people's best interests.

●At the last inspection, we recommended that the provider reviewed how they ensure people sharing rooms have made an informed decision to do so. At this inspection, we checked to see if this had been done and if care and treatment for service users was being provided with the consent of the relevant person.

●Staff had received MCA training and understood the consent and decision-making requirements of this legislation. In people's care files that we sampled, where people might lack mental capacity to be able to make decisions about different activities, this had been assessed for some decisions but not others, including decisions relating to people sharing bedrooms.

●For some people who lacked capacity, it was not always recorded that the person with authority to act in their best interests in this area had been identified and involved in making or reviewing decisions about their

care. This meant it was not evident that relevant people had been consulted with prior to staff making decisions on people's behalf about their support, including for people who shared bedrooms. This increased the risk that people could be subject to support that might not be in their best interests.

● The failure to evidence and to ensure that people and those acting lawfully on their behalf had given consent before being provided with support is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to live healthier lives, access healthcare services and support, 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

●At the last inspection, people had 'Hospital Passports' in use that were designed to be shared with healthcare staff to share information about people's support needs. We found that for some people, their hospital passports did not always contain relevant information to ensure that risks associated with their support and health needs would be managed safely, if they were to access medical services. At this inspection we checked to see if improvements had been made to resolve this issue.

●We found that an on-going review and re-write of all people's hospital passports was underway. Information in some people's hospital passports concerning risks had now been updated. However, some people's hospital passports continued to lack necessary detail or contained incorrect information about their health, communication and other social and emotional support needs.

●This increased the risk that people and healthcare professionals may not be able to understand or explain their treatment options and outcomes. There was also an increased risk that people might not receive consistently effective support if they needed to go to hospital or use other medical services.

● An assessment of people's needs was carried out before they started using the service. If appropriate, family members and health and social care professionals were also consulted. People's differences were respected during the assessment process and there was no discrimination relating to their support needs or decisions.

●However, there was a lack of information in some people's assessments regarding their social needs. Assessments did not always include details about the specifics of the support people needed in all areas of their lives and why this was. Assessments also lacked detail about how best practice guidance informed the support people needed, or what people wanted from their support. This increased the risk that people would not receive effective support or achieve their preferred support outcomes.

●For example, one person exhibited specific symptoms related to their dementia. These symptoms and the recognised best practice guidance around how to manage them had not been considered when assessing their needs. Staff we spoke with confirmed they had not identified these recognised symptoms and they were not delivering support to the person in line with the best practice guidance. As a result, the person was not getting the outcome they needed in this area of their support.

● The failure to ensure care and treatment is designed to meet people's needs and failure to enable and support relevant people to discuss and share necessary information about their support needs before being provided with treatment or support from other healthcare agencies is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● People told us they had support to access care and treatment. One person said, "The GP comes regularly". Staff told us that the GP came at least weekly and nurses monitored people's daily health and well-being. For example, people with bowel care support needs who were at risk of constipation had support to monitor this condition. This helped inform staff if they needed support to access further medicines or healthcare services if their needs changed and they stopped having bowel movements.

● Staff used a standardised system for recording and assessing baseline observations of people's health indicators. This included temperature, pulse, blood pressure and respiratory rates. The system was called National Early Warning Score (NEWS). NEWS was designed to ensure that people's health needs were effectively monitored and, if necessary, people could be supported to receive or access healthcare support and services quickly. Staff were expected to complete NEWS as and when required if noticing a person appeared or was unwell. From records we sampled, we saw that this system was being used appropriately at the time of the inspection.

●People with specific healthcare conditions had received support to access relevant specialist services and make referrals for on-going advice and treatment. For example, for people with epilepsy there were records of seizure activity and advice and guidance had been made to specialist neurologists about how best to meet their needs when monitoring records showed their needs might be changing.

●We have reported more on our other findings regarding how the service works in partnership with other agencies at staff, management and senior organisational level and supports people with specialist healthcare needs to access relevant specialist services in the 'Safe' and 'Well-Led' sections of this report.

Staff support: induction, training, skills and experience

● At the last inspection we identified that staff had not always received appropriate training to be able to carry out their roles effectively. This included training in subjects specific to people's individual needs including dementia and challenging behaviours. There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At this inspection we looked to see if the provider had made necessary improvements and if this breach of regulations had been met and found that it had not.

● Since the last inspection, nearly all permanent staff had now received training and updates in subjects specific to the needs of people using the service, including dementia and challenging behaviour. However, this training had not ensured that people were always being supported safely or effectively. We have commented more on the safety and effectiveness of staff's challenging behaviour training and practice in the 'Safe' section of report.

●There were not always enough staff suitably deployed to ensure that people's eating and drinking and activity support needs were met in an effective or personalised manner. We have commented more on this in the 'Effective' and 'Responsive' sections of this report under the headings 'Supporting people to eat and drink enough to maintain a balanced diet' and 'Planning personalised care to meet people's needs, preferences, interests and give them choice and control'.

●The failure to ensure enough suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Permanent staff training was regularly updated either via on-line courses or with face to face sessions. Staff told us they thought the training they had received, including dementia training was helpful in giving them better knowledge about how to support people effectively. One staff said, "The dementia training was very useful, understanding the differences of dementia is really important and that you need to react differently to different people."

●Permanent staff were given an induction and support from management and colleagues within the provider's organisation when they commenced employment. Staff working at the service had received regular supervisions from management and clinical staff once their probation had been completed, including an annual appraisal.

●The provider's induction and probation processes were currently being revised to ensure they were more comprehensive. This included the expectation that all new staff received relevant training and supervision that met Care Certificate Standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve.

●The service was also committing to re-training staff in e-learning modules that correspond with the care certificate learning if their previous induction and training did not include these equivalents. This would help give staff improved knowledge and skills to understand and know how to support people as effectively as possible.

● The provider was currently using agency staff to backfill staff vacancies. Where possible the provider booked the same agency staff to ensure continuity in their knowledge and experience of supporting people using the service. Agency staff were offered an initial induction. We have commented more on this in the safe section of the report.

● Agency staff were supported to have relevant training to enable them to have the necessary skills to support people effectively via their respective agencies prior to starting work at the service. For regular agency staff, the provider was able to offer additional training in areas of practice relevant to the needs of service users if necessary, although this opportunity had not been undertaken for most of the agency staff working at Forest lodge at the time of the inspection.

●People and their relatives said that they did not have concerns about staff knowledge and experience. One person said, "Staff do understand me as well as possible". Another person said, "I do get all the support I need." A relative said, "They understand him well, they give him all the support he needs".

Adapting service, design, and decoration to meet people's needs

● People's bedrooms had been personalised with their own pictures, decorations and furnishings. Most people had their own bedrooms with en-suite facilities if they wanted to spend time alone. Some people at the service shared bedrooms. There were arrangements to ensure people had time alone when being supported with intimate personal care. However, it was not always recorded what arrangements there were to allow people time alone for social reasons. We have commented more on arrangements for people sharing bedrooms in the 'Effective' and 'Responsive' section of this report.

● The premises had been adapted to accommodate people with physical disability support needs. Equipment such as handrails had been installed in communal areas and individual bathrooms and

bedrooms to support people with transferring and walking from one place to another. There was a lift to help people move between floors. There was a call bell system in bedrooms and communal areas of the home that allowed people to alert staff if they needed assistance. There were ramps instead of steps in some communal corridors to help allow for wheelchair access.

●The service was set in private grounds which people could access. There were separate self-contained outside gardens and spaces. Due to steep and potentially dangerous steps in the self-contained garden areas, people with identified risks associated with their dementia and mobility support needs could not access these outside spaces independently. Due to lack of available staff to accompany people, this limited the amount of time and choice people had about whether they could go outside when they wanted.

●There was appropriate signage on doors to toilets, bedrooms and other communal rooms and facilities. This signage helped people with dementia to be at ease in the service and remain as independent as possible.

●There was a large communal lounge where people could spend time with each other or with visitors. There was a separate 'library' that had been decorated with wallpaper depicting shelves of books. There was a separate 'memory' room, that had been decorated with artefacts and pictures from the 1940s and 1950s, including a replica of a village shop from this period.

●However, people and staff told us these areas of the service were hardly used by people and that the artefacts and decorations in the memory room were not thought particularly beneficial to people's needs. The activities staff we spoke with felt these areas would be better utilised and more beneficial in meeting people's needs if they were refurbished and re-designed to accommodate people's social and activity needs.

●We recommend the provider seeks advice and considers how to improve the design and adaptation of the home and outside spaces to better meet the needs of people and promote the independence of people.

Supporting people to eat and drink enough to maintain a balanced diet

●We have reported on how choking and other risks to people with complex eating and drinking needs are identified and managed in the 'Safe' section of this report.

●People were offered a choice of whether they would prefer to eat in their rooms or in a communal dining area. Many people were supported to eat in the communal dining area during lunch. There was a very busy crowded and noisy environment in the dining area. Music was playing throughout and there was limited space for staff to move around when serving food. Three medicine rounds were on-going as people were eating. There was congestion in the space available from the high volume of wheelchairs, food and medicines trolleys.

●People were all served lunch in one sitting at a set time and staff were rushed due to the volume of people requiring support. The three nurses administering medicines routinely broke off from their tasks to help support people to eat and routinely interrupted people's mealtime support to administer medicines. Some people waited for extended periods before being supported to eat, with no consideration as to how to keep their food warm.

●Staff told us that previously other areas of the service had been used to provide alternative spaces for

people who wished to eat together in a less crowded environment. There had also been two sittings, where people who required more support with eating could be assured they would not have to wait for staff to help them. This also helped ensure that for people with dementia care needs the environment was not as confusing or chaotic.

●An area of the service which included cooking facilities where people using the service could prepare and cook their own meals with support had been turned into a staff room. Staff felt that these changes had impacted on the ability to ensure they were delivering appropriately spaced and flexible meal times.

●We discussed this with the registered manager, who advised they would be reviewing the lunch time arrangements as well as the use of alternative dining and cooking areas of the service to help resolve these issues and ensure people enjoy mealtimes as much as possible.

●People were supported by staff to regularly put forward ideas for what they would like to eat, including cultural or religious preferences. The chef used this information to plan menus in advance. Menus included varied choices and were changed regularly, the chef aimed to provide a balanced diet that met people's nutritional needs as well as their preferences. People told us they all enjoyed the food.

● People told us they had enough to eat and drink. People were supported to maintain adequate levels of hydration throughout the day. People's weight was monitored if there were concerns that they may be at risk of malnutrition and actions were taken to manage this risk. For example, by providing calorie fortified meals or supplements.

Requires Improvement

Is the service caring?

Our findings

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

●People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence, supporting people to express their views and be involved in making decisions about their care

Since the last inspection, the provider had failed to take reasonable steps such as replacing carpets and ensuring adequate cleaning took place to prevent offensive odours in the premises. This meant that people had continued to live in an environment of unpleasant smells for an extended period, which was undignified and disrespectful. We have commented more on this issue in the Safe and Well-Led sections of this report.

●At the last inspection we identified issues regarding people who shared bedrooms and made a recommendation that they support people to document they had made an informed decision to do so. We have commented on this in the Effective section of this report and found that the service had not acted on the recommendation.

●Alongside this issue, we also identified there was no guidance available for staff to ensure people's privacy, dignity and their well-being were continuously considered and respected when supporting them in their shared bedrooms. At this inspection we checked to see if this issue had been addressed and found that it had not.

● Shared room care plans and risk assessments were not yet in place for all people who shared bedrooms. Where these were in place, for some people staff could not locate them, and these were not available during the inspection. This meant there was continued lack of documentation and risk that staff may not be ensuring people's privacy and dignity needs were respected whilst sharing a room. For example, people sharing rooms received personal care in their rooms. Privacy was limited in the shared space and there was no guidance for staff about what action to take should people require intimate personal care with the other person present. We have commented more on care planning and associated documentation and the risks this presents to people in the safe and responsive sections of this report. The provider subsequently sent copies of one person's shared room care plans and risk assessment that could not be located following the inspection.

● We were unable to obtain the views of people who were currently sharing bedrooms. We discussed the continued risk that people's privacy and dignity needs may not be met for people who shared bedrooms with staff and the registered manager. Staff told us people sharing rooms got on well. There had been no recorded incidents related to privacy and dignity issues for people sharing rooms.

●Other people we spoke with told us staff respected their privacy and dignity. One person said, "They

absolutely treat me with dignity." A relative told us, "They absolutely treat them with respect at all times." We observed staff being mindful of people's dignity and privacy. For example, knocking on people's doors and waiting for a response before entering. We observed staff being discreet and respectful when a person approached them asking for support with personal care, reassuring them quietly and leading them gently away from communal areas into their private bathroom.

●People were encouraged to be as independent as they wanted to be. One person said, "Staff do not stop me doing anything". Another person said, "They let me do whatever I want…they will help me when I need it." Staff told us they always respected people's independence when they were supporting them. For example, we were told how staff made sure they encouraged people to perform tasks themselves wherever they were able to do so safely, such as washing during bathing or when getting up and walking around.

●People told us staff were patient, which helped them feel able to express their views on their care. Staff told us making sure that they always listened and respected what people were saying was important. One staff said, "I ask people all the time what they want". They gave an example of how they always offered people a choice when supporting them to dress saying, "It's her life, it's clothes she has to wear all day it should be her choice."

● People told us staff were caring. Staff took time when supporting people to speak with them in a relaxed and friendly manner, about how they were and how their day was going. One person told us, "They treat me with kindness". People confirmed this approach was effective in making them feel like they mattered. One person said, "They are considerate, we have some banter".

●People's personal information was stored securely. There were data protection and record keeping polices in place to guide staff and help make sure that people's personal information was used and shared correctly.

Ensuring people are well treated and supported; respecting equality and diversity

● The registered manager and staff were always aware of and promoted fairness and respect of people's diversity when supporting them. Staff received equality and diversity training during their inductions. People and their relatives did not raise any concerns about how staff took people's preferences and needs into account, including those related to their protected and other characteristics under the Equality Act 2010. One person said, "They respect my choices."

● Staff communicated with people in accessible ways. For example, staff spoke to people clearly, and positioning themselves to be able to maintain eye level contact during conversations. Staff allowed people time to respond and re-phrased questions and sentences using different or less complicated language if people appeared to be having difficulty understanding. This helped make sure people knew what was being said and that they were being listened to.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● At the last inspection we found the service was not providing personalised care that met people's needs. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following the last inspection, we asked the provider to send us an action plan telling us how they would improve. At this inspection we looked to see if the provider had completed the actions and made the necessary improvements to meet this breach of regulations and found that they had not.

●At the last inspection we identified that people's activity support was not personalised or meaningful and people did not have support to access the community or opportunities to participate in social groups.

●The provider had told us about actions they had taken to address the issue. These actions included support and regular reviews of activity support by staff and the registered manager. The provider had told us that there would be specialist input from and regular review of activity planning and delivery from a newly appointed 'engagement and involvement lead' manager to ensure activities met people's individual needs and preferences. The provider also told us that people would receive regular support to follow their social interests within the community. The service would fully utilise different environments within the service including the gardens when supporting people with activities.

●We spoke with the activities co-ordinator and activities assistant who confirmed that since the last inspection there had been no comprehensive review of activity provision within the service by staff and management. The activities assistant told us, "I don't think anything has changed." The activity co-ordinator said, "We have not specifically discussed activities since the last inspection and we are still using the same scheduling and planning".

●The activities staff were not aware of the appointment of an 'engagement and involvement' lead within the provider's organisation or of any plans to involve them in supporting a review of activity provision at the service. The co-ordinator said, "It is probably an oversight. We are a bit isolated in this service". The regional manager confirmed that activities staff would not have heard of the engagement and involvement lead's position or pans to support the service, as this had not yet been communicated to them. The regional manager told us this was because the planned support had been delayed due to the provider prioritising this resource within other services in their organisation.

●People said that there were different activities on offer most days. A review of activity logs and forthcoming schedules confirmed this. However, activities offered were generic, group based, and similar activities were offered on a rolling basis month by month and these did not always reflect people's individual's areas of interests. There was a lack of available transport and drivers. This meant that people had not been able to receive regular support to attend social events or meet people with similar interests from the wider community.

●We discussed this with the activities staff. Although there was information available and people and families had been consulted with about people's individual likes and dislikes, they confirmed that they did not always consider this when planning activities. Although the activity staff would like to vary schedules and provide more individually meaningful activities, due to only having three permanent activities staff, they were limited to offering large group activities. The activities co-ordinator said, "It is a routine schedule, it is difficult to have smaller groups".

●There were separate 'library' and 'memory room' areas that were available as additional communal spaces alongside the lounge, but these were seldom used. This meant activities were currently almost exclusively planned to take place in the communal lounge. This further restricted the provision of personalised activities. The service had also stopped using other areas that had previously been used to facilitate spaces to support people with individual or smaller and more personal group activities. Communal garden areas were currently unsafe unless people were supported and were not routinely being used for non-large group activities, which occurred infrequently.

●The activities co-ordinator said, "We used to have a much better set-up, there was a separate designated area that provided more space for smaller and individual activities, including a kitchen where we did cooking with people, that got turned into staff quarters. We used to have more frequent smaller groups in the room that is now a memory room and the library, and these rooms are hardly used at all now".

●There was generally only one, or at most, two activity staff working each day and other support staff did not get involved in supporting people with individual or group activities. At weekends there were sometimes no activity staff available. Any activities had to be suitable to be facilitated with these limited staff numbers. The activities assistant said, "There is not always enough activity staff and we can't be in the lounge or upstairs or in other areas of the service at once". The activities co-ordinator said, "We are understaffed".

●The service was situated in a rural area and there was a lack of regular public transport. There was one mini bus available for the service but only one staff member available on certain days of the week who would drive the mini bus. We were told that the equipment to secure people's wheelchairs in the mini bus was not working well and was difficult to operate and that the activities co-ordinator who was also the main driver at the service struggled to support people in wheelchairs to use the transport. People who required support to access healthcare services were prioritised when planning travel arrangements over community activities. This further restricted who could and could not leave the service to access the community.

●We were told that it was usually the same small group of more able people who left the service and that due to limitations there had been no regular access to community groups. One person said, "We do go out but not often." Another person said, "We do go to a luncheon club sometimes, but less often than before".

●At the last inspection care plans included limited detail about people's individual likes and dislikes and interests. Staff understanding of people's needs and wishes in all areas of their life was therefore limited and not always considered fully when planning people's care. Information about people's care and support,

including care plans was not always made available in the most accessible way for people.

●The provider had told us about actions they had taken to improve. These included updating care plans with more personalised information to help plan and deliver care that was responsive to people's needs and preferences in all areas of their lives. The provider also told us that individual plans about the most accessible means of communicating with people about their care would also be developed.

● People, or those with the authority to act on their behalf, had been involved with planning their care during the initial assessment process. This helped make sure staff knew people's individual support needs and abilities. However, the initial assessment process did not include a balance of detailed information regarding people's personal history, individual likes and dislikes, interests and how these informed their support needs and choices. This was reflected in people's care plans, which lacked personalised information. People also often had several care plans containing different, inconsistent or conflicting information. This increased the risk that staff could be misinformed or not receive information and would not understand how to offer person centred support to people.

●Reviews of people's care were taking place. People's formal engagement in the review process was limited, according to their needs and levels of engagement. Staff reviewed people's care plans regularly but mainly relied on using daily notes and verbal handovers between the registered manager and staff to share information about any changes to people's level of support needs. However, we found this review system was not always effective. For example, it was not always evident that staff had acted to put any necessary support in place straight away in a timely manner, if someone's needs had changed.

●Although people had some recorded plans about their preferred method of communication, including consideration of how best to share information for people may have a disability or sensory loss, information about people's care was not always available to people in the most accessible manner.

●For example, information regarding activity schedules was written on a board located in a back stairway which was difficult for most people to access. People did not have individual copies of activity schedules or other information about their support, such as care plans, made available to them in ways that were easy for them to understand.

●Staff and people told us they mainly talked with each other to confirm that their individual needs and choices were understood by staff. However, a reliance on informal verbal communication increased the risk that people would not be in as much control as possible of the planning and delivery of their support.

● A visiting health and social care professional told us "There is a lack of personalised detail, information is often duplicated or does not link up between plans. There is a variation in quality, depending on who has written the plans".

●The failure to do all that is reasonably practicable to make sure people who use the service received person-centred care is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manager told us that work was on-going in tandem with external support to improve staff confidence and ability to write and review care plans which would help them to be able to delegate this task more effectively as at present they had assumed a lot of responsibility for doing this themselves.

●The activities co-ordinator told us they had recently started to independently look at how they could make activities more person-centred and responsive to people's individual needs. For example, they had contacted an external company to arrange for personalized MP3 players for people with dementia. This would allow people to upload their favourite songs, which had been found to be beneficial in stimulating emotions and the ability to converse for people with dementia.

Improving care quality in response to complaints or concerns

●No person or relative we spoke with had made a complaint but told us they felt staff were approachable if they needed to do so. The registered manager and staff told us they looked to see what they could improve on if they did receive any complaints. Staff gave an example of how feedback about an issue with person's laundry had led to changes being made to staff responsibilities to help ensure the issue did not occur again. There was a complaints policy and records showed any formal complaints had been responded to appropriately in line with the policy.

End of life care and support

● Where appropriate, some people had advanced care plans that recorded how they wanted to be supported when approaching their end of life, including their religious or spiritual wishes. People had information regarding the appropriate approach to them being supported with their end of life care, regarding emergency resuscitation in the event of a medical emergency. There was an expected pathway for arranging any necessary medical equipment and resources needed to support people approaching their end of life. This would help to ensure that they could be as comfortable as possible in their final days.

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

●There were widespread and significant shortfalls in service leadership.

●Leaders and the culture they created had not assured the delivery of high-quality care.

●Some regulations were not met.

Managers and staff being clear about their roles and understanding quality performance, risks and regulatory requirements, working in partnership with others, continuous learning and improving care

●At the last inspection we identified that the service was not well-led. There was a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. At this inspection we looked to see if the provider had made necessary improvements to meet this breach of regulations and found that they had not.

●Since the last comprehensive inspection in May 2018, five breaches of Health and Social Care Act 2008 (Regulated Activities) 2014 had continued not to be met, including regulations 9, 12, 15, 17 and 18. Some of the specific issues we found at this inspection were the same as had been reported after our last inspection. Despite action plans submitted to CQC by the provider those issues had not been remedied in the year between our inspections. This had left people exposed to risk and poor-quality care in some areas. There were also two newly identified breaches of regulations 11 and 13. This was evidence that the service had deteriorated since our last inspection rather than improved.

●Concerns about choking, managing behaviours that challenge, moving and handling and medicines management have been highlighted to the provider in reports of inspections of a number of their other services. This had not led to shared learning so that care at Forest Lodge was improved.

●Quality assurance and governance systems that were in use included different audit processes, undertaken by the registered manager and internal and external quality support staff. These systems were not currently operating effectively to ensure that staff and management at the service understood their responsibilities and that safety and quality risks, and regulatory requirements were managed appropriately.

● Audits did not always identify or record the actions required to address any quality issues, how these should be prioritised and when they should be completed by. The registered manager and senior management reviewed audits but where actions had been identified, they had not ensured that internal audits were always being carried out as expected by the staff responsible for doing so. We found that quality and safety issues had not always been addressed effectively, in a timely manner, or at all.

●Although the registered manager told us they kept informal plans based on the findings from individual audits to prioritise and track the progress and completion of actions, the service did not have an operational centralised development plan at the time of the inspection. The lack of centralised and easily accessible quality and safety information meant there was an increased risk that the service would continue to fail to identify or act on issues. For example, actions to address breaches of regulations identified at the last inspection had not been completed effectively or at all.

●Internal communications and management support processes were further currently impacted by poor internal information technology systems. Although improvements to the systems were scheduled to take place in the future, the service was not yet fully linked up to the provider's centralised information sharing databases and systems and much of the IT technology at the service was not operational due to technical issues or was obsolete.

●This meant there was a continued reliance on sharing of information relating risks to quality and safety at this service, including identifying and overseeing the progress of expected actions to address issues, via access to local plans and verbal communications between staff, management and senior management. This increased the risk that governance information would be inconsistent or inaccurate and this would further impact on the ability of the service to continuously learn and improve the quality of care it was delivering.

●Other issues identified during this inspection regarding keeping people safe from abuse and avoidable harm, managing risks, deploying enough suitably skilled and experienced staff, delivering person-centred care, obtaining care and consent, maintaining care records and operating effective quality assurance systems and governance frameworks have been identified to either have developed or continued since the last comprehensive inspection in May 2018.

●The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, and service performance was evaluated and improved is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●The registered manager and provider acknowledged the issues with quality assurance, governance systems and information sharing and how this was impacting on promoting a shared understanding between staff and management regarding quality and safety risks. There was also acknowledgement that there was a need to improve information sharing and working process with external partners to help improve the quality of care.

●The registered manager was committed to supporting RGN's and direct support staff by improving processes to account for their decisions and improve performance. The registered manager was also keen to improve the ability of the service to work effectively in partnership with external stakeholders to learn, improve and develop. The health and social care professional involved with supporting the service with care planning processes and documentation told us they were evidence of this commitment and had seen an improvement since they had started work with the service and that staff and the registered manager were supportive of the need for changes.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

●Although quality and safety issues, including the planning and delivery of person-centred care, continued to not meet regulations, staff, people and relatives were generally positive about the culture of the service. One person said, "Overall I am happy. The manager is approachable". Relatives said staff and the manager were visible and transparent about their care their loved one received, including when things had gone wrong. Staff said although communication could sometimes be improved, there was a supportive atmosphere where they could talk openly to the manager and that everyone was committed to providing good quality care. One staff said, "We all support each other, it is like a family".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager encouraged staff involvement in helping to develop the service via team meetings and individual supervisions. Staff told us meetings generally took place regularly every week and there were more informal chances to share their input into service delivery issues during daily handovers with the registered manager. People and relatives were sent questionnaires to ask for their views on how what was and was not working at the service and what staff could do to make their support better.

●The registered manager was fully committed to promoting a culture where, "Dignity, privacy, respect and kindness is given to all those we support regardless of capacity, age, gender, status and religion." Staff understood this expectation and told us that they would respect all people they supported equally, regardless of their beliefs or backgrounds.

●The provider had recently changed their recruitment policy to make sure that all staff's involvement and engagement with all employees at all levels within the service and the wider organisation would be encouraged and valued equally, regardless of any protected characteristics under the Equality Act 2010.

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 11 HSCA RA Regulations 2014 Need for consent Failure to evidence and to ensure that people and those acting lawfully on their behalf had given consent before being provided with support.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to do all that is reasonably practicable to make sure people who use the service received person-centred care. Failure to ensure care and treatment is designed to meet people's needs. Failure to enable and support relevant people to discuss and share necessary information about their support needs before being provided with treatment or support from other healthcare agencies

The enforcement action we took:

We imposed conditions on the provider's registration. The conditions mean the registered provider must:

Complete a monthly audit in relation to risk management, safeguarding, medicines, activities and infection control at Forest Lodge.

The provider must tell the commission each month who carried out the audit, the findings and actions they are taking regarding any issues.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to do all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users.

The enforcement action we took:

We imposed conditions on the provider's registration. The conditions mean the registered provider must:

Complete a monthly audit in relation to risk management, safeguarding, medicines, activities and infection control at Forest Lodge.

The provider must tell the commission each month who carried out the audit, the findings and actions they are taking regarding any issues.

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 Failure to safeguard people from abuse and improper treatment

The enforcement action we took:

We imposed conditions on the provider's registration. The conditions mean the registered provider must:

Complete a monthly audit in relation to risk management, safeguarding, medicines, activities and infection control at Forest Lodge.

The provider must tell the commission each month who carried out the audit, the findings and actions they are taking regarding any issues.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Failure to ensure adequate cleaning took place to combat odours caused by incontinence.

The enforcement action we took:

We imposed conditions on the provider's registration. The conditions mean the registered provider must:

Complete a monthly audit in relation to risk management, safeguarding, medicines, activities and infection control at Forest Lodge.

The provider must tell the commission each month who carried out the audit, the findings and actions they are taking regarding any issues.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved

The enforcement action we took:

We imposed conditions on the provider's registration. The conditions mean the registered provider must:

Complete a monthly audit in relation to risk management, safeguarding, medicines, activities and infection control at Forest Lodge.

The provider must tell the commission each month who carried out the audit, the findings and actions they are taking regarding any issues.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure enough suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs

The enforcement action we took:

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about staffing.