Aspen Village Limited

Forest Care Village Elstree and Borehamwood

Inspection report

Forest Care Village
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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out a responsive comprehensive unannounced inspection at Forest Care Village on 05 December 2017. This inspection was in response of the concerns the Care Quality Commission (CQC) received from members of the public and local funding authorities. At our last inspection on 30 November 2016 we found the service was meeting the required standards. At this inspection we found that there were serious failings from staff and management to ensure people received care and support in a safe and effective way. Following our visit to the service we were informed by the local authority that Environmental Health officers had served a Hygiene Emergency prohibition Notice on Forest Care Village due to an infestation of cockroaches.

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

Forest Care Village is registered to provide personal and nursing care for up to 178 people aged 18 and over with a range of complex health and care needs. At the time of our inspection 161 people were using the service.

Forest Care Village spreads across three floors and accommodates people in separate units, each of which have separate adapted facilities. Three of the units specialise in providing care to people living with dementia whereas in the remaining four units people have nursing needs.

There was a manager in post who had registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People who were able to talk to us told us that they felt safe living in the home. However seven people and two relatives felt there were not enough staff to meet their needs in a timely way and also that the agency staff working in the home were not knowledgeable about their needs which had impacted on their dignity and general well-being. Some staff also told us they were rushed and felt under pressure to complete tasks not having time to spend with people. We observed staff working in a task led way. For example, asking people to finish their meals in a hurry or moving people without giving people time to actively participate in the process.

Risks to people`s well-being and health were not always identified, assessed or mitigated in a way to reduce them. Where people were assessed as requiring a fortified diet to help reduce the risk of malnutrition they were not provided this by the kitchen staff who were not aware of people's needs. Where people had pressure relieving equipment in place to help prevent the development of pressure ulcers the checks carried out by staff did not effectively identify faults or wrong settings on air mattresses. There was a risk that this

shortfall had contributed to people developing pressure ulcers.

People who lived with specific health conditions had no care plans in place to address this area of their needs and staff had no guidance on how to maximise people`s health. People`s end of life care needs were not assessed, there were no plans in place to evidence that people`s wishes, likes and dislikes were considered when staff created care plans. Staff could not tell us what people liked and how they wished to be cared for.

People who came to harm because of the measures in place to mitigate risks were ineffective had not been referred to local safeguarding authorities. This meant that further actions had not always been implemented to keep people safe. Staff were knowledgeable about signs and symptoms of abuse and their responsibilities to report. However we noted instances when staff had reported concerns to their managers but these had not been reported to external safeguarding authorities as required under local safeguarding protocols.

People were not always protected from the risk of infections. There were insufficient control measures implemented to help protect people and staff from infectious diseases. Medicine management systems were in place to aid staff to administer medicines safely as intended by the prescriber; however we found in one instance where a person had not received their pain relief as prescribed.

People who had complex health care needs had not been properly assessed and care plans had not been developed around their health needs to offer guidance to staff on how to maximise people`s health and keep them safe.

People with less complex care needs told us they knew about their care plans. However, they told us they had not reviewed these for a long time. Care plans we reviewed for people who were less able to communicate with us were not up to date and not reflective of people`s current needs. Care plans we reviewed were written in a style that did not promote people`s dignity.

People were not asked for their consent to the day to day care and support they received from staff. We observed staff assisting people without communicating with them or asking for their involvement. People who were less able to communicate verbally had not always had their dignity and privacy protected by staff. Staff did not follow the principles of the Mental Capacity Act 2005 (MCA). Staff were not aware if people had Deprivation of Liberty Safeguards (DoLS) authorisations in place which put restrictions on people`s freedom in order to keep them safe.

People with less complex care needs and who were more independent were positive about the care and support they received and the way staff supported them to remain independent and participate in social activities. They told us staff protected their dignity and privacy and they were very happy living in the home.

Staff told us they received training and support to carry out their roles effectively. We saw that there was an effective training monitoring system used by the registered manager to identify staff who needed refresher training. Recruitment processes were robust and ensured that the staff employed were suitable to work in this type of care settings.

People told us they liked the food provided to them and they had enough choices. People who had to maintain a healthy diet and lose weight were appropriately supported by staff; however the needs of the people at risk of malnutrition or requiring special diets were not always met effectively.

The atmosphere at Forest Care Village was welcoming throughout the day. People who were able were congregating in the main foyer where they had drinks and cakes served and had live entertainment, however people who spent time in their bedrooms were at risk of social isolation.

Some people told us they did not know who the registered manager was; however they knew the unit manager responsible for the unit they lived in. They gave us mixed views about if they felt confident to raise concerns and complain to the managers. Some people told us they did not feel they had a voice; other people told us they felt listened to.

The registered manager had no formal systems in place to provide them with an overview of the service. They had no system to identify themes or trends and were dependent on feedback from the clinical manager for their information and on different audits carried out on the units. However we found that these audits were not consistent and at times only provided limited information about the issues found. There was little evidence found in meeting minutes that lessons were learned or that actions were implemented to improve the quality of the care people received.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to 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 their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always kept safe from harm.

Staff were not always aware of risks to people`s well-being and health and how to effectively mitigate these.

There were not sufficient staff deployed to meet people`s needs in a timely way.

Incidents identified and reported to managers were not always escalated and reported to external safeguarding authorities.

People`s specific health conditions were not always assessed and guidance was not in place for staff to know how to maximise their health.

People were not always protected from the risk of infections.

People who were identified at risk of choking, malnutrition and at risk of developing pressure ulcers had not had these risks sufficiently mitigated by staff who had limited guidance on how to keep people safe.

People received their medicines from trained staff who followed safe procedures when they administered people`s medicines, however one person did not receive their pain relief as intended by the prescriber.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always seek people's consent before providing care and support.

The principles of MCA and DoLS were not known to staff. Where DoLS authorisations were in place with conditions attached these were not met.

People`s dietary needs were not always known to staff and they

were not always met. People told us they enjoyed the food and they had plenty of choices.

People were supported to access health care professionals as needed to help ensure that their health and well-being was maintained.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive care and support from staff in a kind way.

People`s dignity was not always maintained.

Staff had limited knowledge about people`s likes, dislikes and preferences.

Some people told us that they had not been involved in their care planning and had no review meetings to discuss their care needs.

Confidentiality was not always maintained. People`s records were not always locked away.

Is the service responsive?

Inadequate

The service was not responsive.

People not received personalised care. Care plans were not reflective of people`s likes and dislikes and staff were not knowledgeable about these.

Care and support was delivered to people in a task orientated way.

People`s care plans were not detailed around people`s needs to give staff sufficient guidance to meet their needs effectively.

Opportunities were provided to help people pursue social interests and take part in meaningful activities relevant to their needs; however people who were not able to leave their rooms had limited social activities offered to them.

People who lived with life limiting conditions had no plans in place for staff to know their wishes and preferences about the care they should receive nearing the end of their life.

People told us they could raise their issues with the unit managers; however they did not know who the registered manager was.

Is the service well-led?

Inadequate

The service was not well led.

The systems and processes used by the registered manager to quality assure the service provided to people were not comprehensive and did not identify the concerns we found in this inspection.

The registered manager was not able to provide us with evidence of an effective monitoring system they used to ensure the service was safe.

People`s care records were not up to date and did not provide sufficient detail for staff in how to deliver care and support to people in a safe way.

Some people told us they were not confident to raise concerns within the home for fear of repercussions.

Forest Care Village Elstree and Borehamwood

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by some notifications we received where the cause of death was unclear. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people's care. We received concerning information regarding possible abuse by some staff members towards a person living in the home. This inspection examined those risks.

We also received information about 14 safeguarding enquiries that were under investigation by the local authority safeguarding team about allegations of neglect.

The local Clinical Commissioning Group had carried out targeted reviews of people with nursing needs in Forest Care Village and they had raised concerns about how people`s Percutaneous Endoscopic Gastrostomy (PEG) had been managed by staff and also about people`s care plans not being detailed enough or up to date to give staff enough information about how to meet people`s needs safely. (PEG is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.)

The information shared with CQC about these incidents indicated potential concerns about the management of risk of falls, nutrition, staff not recognising signs and symptoms when people`s health needs changed and that people received care and support which did not meet their nursing needs. This inspection examined those risks.

Due to the widespread concerns we took the decision to carry out a comprehensive inspection and look at all areas of the care delivery.

The inspection was carried out on 05 December 2017 by five Inspectors, two experts by experience and one specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Our specialist advisor was a registered nurse for learning disabilities, experienced in autism, acquired brain injury, dementia, challenging behaviour, profound and multiple disability and mental health. The inspection was unannounced.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 23 people who used the service, seven relatives, 26 staff members including, care staff, staff working in the kitchen, nursing staff, unit managers and the registered manager. We also talked to two members of the provider's senior management team. We looked at care plans relating to ten people and six staff files.

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 communicate with us. We also looked at other care records such as turning charts, food and fluid charts, monitoring charts and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe at Forest Care Village. One person told us, "Living here is nice, I feel safe." Another person said, "I feel safe." One relative told us, "[Person] is kept safe." However other people who were relying on staff support for every aspect of their care told us they did not feel that the care and support they received was always safe. One person said, "An agency nurse once shouted at me." Another person said "I've been living here, you [inspector] don't, I know how it is, I don't want to make them [staff] more busy and I don't want to get on the wrong side of them."

People gave us mixed views when we asked if there were enough staff to meet their needs in a timely way. One person said, "There are enough staff." Another person said, "I think there are enough staff." A third person said, "Usually staff come within 10 minutes of pushing the call button." However other people also told us that it was normal to wait for up to two hours to get support from staff. This was usually in the mornings when people said they waited for long periods of time to use the toilet. One person told us, "I don't even use my bell now; they come in turn it off, say I'll be back in a minute so you just have to wait." We asked if we could press their bell to get them some support and they told us, "There's no point…You've just got to accept it and they will come when they are free." Another person said, "These guys [pointing towards staff] are run off their feet." A fourth person said, "After breakfast, I was left till 11.00 before being helped to the toilet."

A person told us after pressing their bell, "I don't believe that anyone will come." However, we noted that a staff member did come, put them on their bedpan and then left the room without checking the person was comfortable. The person was calling out that the bedpan was hurting them so we had to intervene and encouraged the person to seek further assistance.

We asked staff if they felt there were enough staff to be able to meet people`s needs. Again we received mixed views about this. Some staff told us there were enough staff, however the majority of the staff we spoke with told us there were not enough. One staff member told us, "We could do with more staff on [name of the unit] as it's a heavy unit." Another staff member said, "Feels like there is not enough staff or support. We have to cover another unit and that sometimes leaves us very stretched." When asked about specific risks to people due to time pressure the staff member said, "People might have to stay in bed longer, risk of pressure sores, delay in getting meals and medication."

We saw that staff rotas were completed and planned for in advance. Team leaders told us that they had set numbers of staff for each shift and in case regular staff were absent agency staff were used to cover available shifts. They told us that agency staff always worked paired up with permanent staff to ensure they had support in meeting people`s needs. However we saw that this was not always the case and observed agency staff working alone. We also found that monitoring records were not completed in a timely manner and staff told us this was because of lack of time. The registered manager told us that they worked on a four people to one staff ratio in the home and that they also took account of people`s needs. However they were not able to evidence how people`s changing needs influenced staffing numbers on the unit.

People had risks to their well-being assessed. However measures in place to mitigate these risks did not contain sufficient guidance for staff to understand how to keep people safe. We also found that some of these risk assessments were generic and pre-printed which indicated they were not individualised to each person's risks. For example, one person's assessment talked about correct fitting footwear when mobilising but the person was cared for in bed and transferred with the aid of a hoist.
One person had been identified being at high risk of taking their own life. The risk assessment instructed staff to monitor this person hourly, however did not detail what staff should check or the signs of this person being distressed or unwell. On the day of the inspection we observed that from 10am to 12.30pm staff had not checked on the person. We checked the hourly observation record and this was not completed from 10am to 14.30 when we requested a copy of this. This demonstrated that the risk to this person taking their own life was not being sufficiently mitigated.

Some people living in the home had swallowing difficulties and were assessed by the speech and language therapists (SALT) to ensure they were on the correct diet and the risk of choking was sufficiently mitigated. We observed that staff did not always follow these assessments. For example, a person was assessed as needing to be elevated while eating and staff had to communicate clearly what they were doing as the person was blind. We observed staff at breakfast and lunch not following the risk assessment and the person experienced severe coughing. Staff had not positioned the person up-right and had not communicated with the person to say when they were about to give them food. The person had a history of chest infections, the risk of which was increased by aspiration. The person had been assessed as requiring thickened fluids. Guidance in their care plan gave inconsistent information about the quantity of thickener to be added to 200mls of fluid. The quantities varied between 2 scoops, 3.5 scoops and 4 scoops. Staff spoken with all gave us different answers in regards to the quantity of fluids required. This meant the person was at risk of having the wrong consistency fluids further increasing the risk of aspiration and associated chest infections. In addition, the person was to have a 'smooth diet with no bits' according to the information from the speech and language team. However, we observed staff giving the person thick porridge which was not blended and had lumps in it. This demonstrated that staff were not aware of the risks to people which put people at significant risk of choking or having other adverse reactions as a result.

Some people were assessed as requiring bed rails to keep them safe. Staff told us that all bed rails required bumpers to keep people safe from the risk of entrapment. Bed rail assessments confirmed that bedrails had to have bumpers on to protect people from the risk of entrapment. However we found that for two people this had not been followed by staff. We saw two people on the day of the inspection who had bed rails in place with no bumpers on.

Some people were identified being at risk of developing pressure ulcers. We found that these people had specialist equipment in place to mitigate this risk. Although staff regularly checked the equipment we found that these checks were not always carried out thoroughly. For example, we found that although the person weighed 58.1kg, the pressure relieving mattress was set to 90kg. This person had reoccurring pressure ulcers therefore the incorrectly set mattress increased the risk of them developing more pressure ulcers.

We found that the care plans and the instructions given to staff by the provider`s TVN nurse were not always followed. For example there were no wound care plans developed to incorporate the advice given to nursing staff by the TVN. Care notes were unclear, some stated that the wound had healed, however, staff told us it was still healing. We also found that where the physiotherapist advised staff to position people in a certain way staff had not always followed these instructions. For example, we observed a person who staff had to reposition regularly. On the wall of their bedroom the person had pictures to show how staff had to position cushions under the person's elbow and knees to reduce the pressure to certain areas of their body and support the person`s posture. We observed this person in the morning and noted that there were no

cushions in place as per the instructions provided.

Another person in receipt of one to one support had been identified at high risk of developing pressure ulcers due to their specific health condition and spending a lot of time in bed. The provider`s TVN specialist raised concerns that staff did not notice pressure damage to the person's heel until the person complained of pain. The TVN also found the mattress set at 80kg despite the person being only 62kg, that mattress checks were not carried out daily and that the mattress was not functioning correctly. None of these issues had been identified by staff who provided continuous support to this person during the day. On the day of the inspection we found that positioning charts had not been completed for this person since the TVN visit on 4 December 2017. We found a separate diary was maintained by staff providing one to one support to the person and they made an entry every 15 minutes between 08:00 and 20:00 hours. Entries stated: lying in bed, asleep, watching TV. One sentence every 15 minutes without evidence of the person changing position or if they were in pain. The provider told us the person was able to change their but this was not reflected in the person's care plan.

We found that another person who had been admitted with pressure ulcers on their back had a sore area in the creases of their stomach. There was no mention about this in their care plan other than a photograph so we asked staff who told us, "That is just a moisture lesion." However, there was no plan for this wound and no record of care delivered to address it to prevent further damage. Moisture lesions develop due to exposure of excessive moisture and are not necessarily caused by pressure. However these can aggravate and cause tissue damage and turn into pressure ulcers if they are not treated or prevented. The risk is even higher for people who are already at risk of developing pressure ulcers. This in addition to the examples of staff not responding appropriately where people had or were at risk of developing pressure ulcers demonstrated that people were being exposed to unnecessary risks of developing pressure ulcers and the associated complications and discomfort.

People who had been at risk of falls or sustained falls had not had their care plans reviewed and staff were confused as to what measures were implemented to try and reduce further falls. One staff member told us that one person had four falls in the previous three weeks. They told us that they came on duty recently and they noticed a bruise on this person`s forehead but nothing had been noticed or recorded by waking night staff. They completed a body map, contacted the relative and also completed an incident form. However the person's care plan and the falls risk assessment had not been updated following the falls they had in previous weeks. This demonstrated that staff did not have an awareness of the risks to people who used the service and that appropriate actions were not taken following accidents and incidents to mitigate the risks of further harm. The registered manager told us they had ordered an alarm mat for the person so staff were alerted when the person needed help, however we saw no evidence of this and staff working on the unit were not aware.

People who were at risk of losing weight had not always had their nutritional needs safely met by staff. We found that where people experienced weight loss staff had not always followed instructions from dieticians to effectively meet people`s needs and prevent further weight loss. For example, one person had lost a significant 3.9kg in April 2017 and a further 2kg in June 2017. The dietician involved in this person`s care stated that the total weight loss was a significant 10kg in 2017 which was equal to 15% of the person`s body weight. The dietician instructed staff to give a fortified diet to the person; monitor food and fluid intake; for their GP to prescribe build up drinks for them and for the person to be weighed every two weeks. However, this monitoring and guidance had not been followed. Fluid and fluid intake charts were not commenced, weight had been only taken on the 03 December 2017 and the kitchen staff had not provided fortified food. The person had not had their weight recorded for November 2017 and lost a further 0.3kg`s between October and 03 December 2017. This demonstrated that staff had failed to follow guidance from health

professionals which put people at risk of further weight loss and associated health concerns.

We also observed a person who lost a significant amount of weight since they moved in the home in September 2017. Guidance was introduced to support their nutritional needs in November 2017. This advised staff to commence fortified diet, offer additional snacks between meals, support at meal times, feed slowly and sit person upright and monitor weight. We found that staff were monitoring the person`s weight. However, we observed the person being supported to eat not sitting up properly. When we asked the staff about this they were not aware of the guidance in the person`s support plan and told us that this was a problem when information updates were not passed on. We looked at the person's food and fluid charts and we found that no additional snacks had been documented to demonstrate they had been given. When we spoke with the kitchen staff we found that there was no guidance about fortified food for this person. This meant that the person was at risk of harm by not having their identified nutritional needs met because of the lack of effective communication.

We also reviewed a person who had been assessed as needing a low potassium diet due to a medical condition they lived with. Staff were not aware when we asked that this was a requirement for the person. We also asked the staff in the kitchen if they were providing this diet to the person, however they told us they were not aware of this requirement and they were not providing this. This meant that the person was at risk of their health deteriorating because the systems and processes used by staff to ensure people were protected from harm were not effective.

Systems to promote infection control were not always effective. Although we saw staff used protective personal equipment (PPE), we did not see staff washing their hands. We also noted that some corridors and a kitchenette had debris on the floors where they had not been sufficiently cleaned. We observed one staff member using the same green cloth and bottle of polish to clean the nurse's station, the nurse's office, the medicines and treatment room and the sluice and laundry room. When we asked them if they had been provided with enough equipment and knew the tasks to complete, their reply was "It's okay. I know." The cleaning trolley appeared to be well stocked and we saw that there were cloths of four different colours. We saw the staff member change their gloves after using the polish and cloth between the four areas before starting to mop the floor. They changed the mop heads to clean the different areas but used the same bucket of water for all areas. Again we asked them about their role and duties, but their reply to every question we asked was "It's ok. I can do. No problem." There was a clear language barrier and they could not understand our questions.

We were told that lessons learned from accidents and incidents were cascaded by the clinical lead through the staff team as a result of weekly manager's meetings. However, the notes of the meetings were not detailed enough to evidence what actions were taken following the meetings and notes on handover forms or communication diaries were sparse and handwriting was difficult to read.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people`s well-being were not sufficiently mitigated to protected them from harm.

There was safeguarding information displayed around the home and staff had received training in relation to identifying and reporting abuse. Staff knew how to report their concerns internally and externally to local safeguarding authorities and they were knowledgeable about whistleblowing procedures. However we found that people were not always safeguarded from poor practice. We were informed by the local safeguarding authorities that they were currently investigating 14 safeguarding concerns in Forest Care Village.

Some people told us that staff were not all nice. One person told us that a member of night staff was, "cross", with them as they had forgotten their name. The person said, "It's the middle of the night, I couldn't help it and because they introduced themselves so now [staff member] barely helps me." The person would not identify the staff member to us. They said, "Most are ok, [staff member] is not. Don't want to tell tales and make it worse."

We found that a person had reported a staff member for their conduct towards them to the unit manager. The record of this discussion was filed between audits carried out on the unit and evidenced that the unit manager had a discussion with the staff member, however there was no further evidence that this had been reported to the registered manager or to local safeguarding authorities for further investigation.

One person was prescribed pain relieving patches for chronic pain every 72 hours and we found this had been given at weekly intervals, meaning that doses of pain relief had been missed on frequent occasions. The person was admitted to the home on 20 October 2017. The next patch was administered on 25 October 2017. Then 01, 15, 22, 29 November 2017. This meant that the person would have experienced increased pain levels. After the 29 November 2017 the patch had been administered correctly, however the person was crying in pain when we observed them at 8am on the day of the inspection. They were unable to summon assistance as the call bell was around the end of the bed where they could not reach. We gave the person their call bell and they pressed it to call for assistance. We asked staff about the person's distress and we were told, "[Person] always has behaviour like that, [they] have dementia." The staff did however inform the nurse that the person was expressing pain. The nurse saw the person and told us that the person had stated they were hungry and arranged for some food. We visited the person at 12pm and they were still crying in pain. They were seated on their bed in the same position as at 8am. We raised this with the nurse who told us that they would get the GP to see them on their visit that day. However, they were unable to explain why the person's expression of pain previously had not triggered a GP review.

When we reviewed the medicine administration record (MAR) for this person we noticed that the `every 72 hours` instruction was circled and had a hand written exclamation mark put next to it. These suggested that a staff member had noticed that the pain relief had not been administered correctly and had drawn attention to the right instructions. However this had not been reported to the registered manager or local safeguarding authorities for further review. The provider had submitted an action plan following the inspection to inform us that they will be reporting this to local safeguarding authorities.

Communication systems used by staff and mangers in the home to share information and keep staff up to date about people`s changing needs were not effective and as a result people were exposed to the risk of harm.

We asked staff how they were updated about people`s changing needs or risks. They told us that they had information given to them on a handover sheet where every person living in the home had been identified detailing their health conditions, diagnosis, special care needs and risks. We reviewed handover documents and found that two of these showed printed names of people no longer residing in the unit crossed out and handwritten names added. However, the information relating to needs, risks and health complications were not updated. This meant that information against people`s names was not relevant to them. This placed people at risk of unsafe practice. For example for one person who was at high risk choking and aspiration and another person who required elevation during their feed regime was not documented. This failure to ensure that staff had the information they required put people at risk of receiving unsafe care. This risk was increased due to the fact that the home was relying on staff from an agency to cover some shifts who did not know people well.

We found that one person who had restrictions applied to their freedom in order to keep them safe was at risk of being deprived of their liberty unlawfully. The person had a standard Deprivation of Liberty Safeguards (DoLS) authorisation issued by local authorities on 19 May 2017 and expired on 07 September 2017. A further application had been submitted by the registered manager on 31 July 2017. The previous authorisation was granted for the restrictions in place; however it had attached conditions to it. These conditions asked the registered manager to liaise with the person`s GP and refer the person to the falls clinic, regular access to community with staff, a record of how often the person had been offered to access community to be kept and record of refusals and also to ensure that the care plan was updated to reflect current level of needs and abilities for the person.

We found that the care plan had not been updated and did not reflect the person`s current needs, and no record or evidence was seen that person was being offered opportunities to access community. We also saw that the one to one support during the day had not been part of the recent application for a renewed DoLS application. This meant that the person was at risk of receiving support in a way which potentially infringed their human rights.

We found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were ineffective systems and processes established to protect people from improper treatment and support.

People's medicines were managed safely in most cases. We checked records and found in most cases these were accurate and quantities agreed with records of stock. Staff had received training and competency checks and we observed them working in accordance with best practice guidelines. Medicine rooms were secured with the keys only held by nurse or senior care staff. The rooms had plenty of storage and a number of additional cupboards were secured. Temperatures were monitored and recorded and fell within the expected range. We noted that where people required their food and medicines administered via percutaneous enteral gastrostomy (PEG) the details included on MAR`s were not consistent. For some people the details included the type of feed, the amount given and information on flushing the PEG`s through with water before and after administering feeds. However for other people there were no details of any flush needed.

We asked for a copy of each person's medicines on one unit. We found that four people who were living with dementia were on anti-psychotic medication. Staff told us that the GP regularly reviewed these medicines and this was confirmed by the GP.

People told us that a practice fire drill was held weekly on Fridays and the gathering point was in the reception area on the ground floor. One person said, "The fire practice is done well." People also had plans in place for staff to follow in case an emergency.

Safe and effective recruitment practices were followed to help make sure that all staff were of good character, physically and mentally fit for the roles they performed and relevant checks were in place such as verifying references. Staff told us before they started working at the service they went through a thorough recruitment process where their employment history was explored, references were requested from their previous employers and a criminal records check was done to help ensure they were suitable for the roles they had to perform.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had been trained and in most cases the training was up to date. People told us they felt staff knew what they were doing. One person told us, "Yes, staff know what they are doing." Another person said, "They [staff] seem well trained." Training included dementia awareness, medicines, health and safety, infection control and first aid. There were some additional subjects for care staff to develop a better understanding of how to support people with end of life care, person centred planning and challenging behaviour. Staff also received training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Although staff had received training we found that not all the staff we spoke with had clear knowledge in relation to MCA and DoLS. Not all staff were able to give any examples of where a person`s liberty may be restricted although they confirmed they had completed the training. One staff member said when we asked them about DoLS, "Sorry I don't know what that means. I have not had any training in that – what does DoLS mean?"

With the exception of one nurse observed to explain to a person about their medicines, staff did not offer choice to people or explain what was happening when providing care. Examples included staff moving people without speaking to them, opening doors without asking, putting bedroom lights on without asking while people were asleep and putting aprons on people in readiness for eating without asking first.

Some staff assumed people did not have capacity if they had a diagnosis of dementia. One person's care plan stated that they had capacity and they were able to make their own choices. However, staff told us that the person did not have capacity. They had failed to link the person's changes in behaviour to poor pain management and made the assumption of lack of capacity without looking at their capacity assessment.

Mental Capacity assessments were completed for some people evidencing that they lacked capacity to take certain decisions. However best interest decisions had not always been undertaken following the right process. For example a mental capacity assessment had been completed for a person who was refusing their medicines. The assessment evidenced that the person lacked capacity and there was reference in the care plan that a meeting had been held involving the person`s relatives and health professionals to agree that the person should be administered medicines in their 'best interests'. There was no record of this meeting to evidence what alternative options were considered and if the decision to administer medicines covertly to the person was the least restrictive option.

The smoking shelter for the entire building was accessed through the conservatory of one of the units on the ground floor. This area was also used as dining room. We observed throughout the inspection people from the home walking through the dining room where people were sitting and eating to access the smoking area. This meant that people living there had no choice but to have people who lived or worked in in the home, walking through their unit.

We found that some people signed to consent to the care and support they received or in some instances people`s relatives signed to indicate they agreed with the care and support people received. However we saw that in most cases people were only asked to consent when they moved into the home and they were not part of a regular review of the care and support needs when these changed and staff had not asked for people`s consent when they delivered care and support.
For example we found that one person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. The form recorded that the person had dementia and was not involved in the decision and their relative was informed after the decision was made so they had not provided a view on this matter. However on the front page in this person`s care plan it was written with big capital letters that they were `For resuscitation`. The two staff members working on the unit could not tell us which instruction they would follow in case of an emergency. This inconsistency put the person at serious risk of not receiving appropriate care and treatment.

We found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the decisions taken in people`s best interest could not be evidenced that there were made following the best interest process and staff carried out care and support without asking people for their consent.

People told us the food was good and they had enough. Comments from people included, "The food is acceptable, but I don't always get what I ordered", "The food is okay", "The food is very good but too large [portions]", "Lunch is hot enough". We observed lunch served in several areas of the home and some people had their meal in a nice and calm environment. However, other people did not have the same experience. In one of the dining areas we observed staff supporting people with their meal and this was not done in a respectful way. One staff member said to a person in a hurried way, "Please eat your food I thought you would have been finished by now." Although the person had not finished staff brought their dessert. Another staff member was seen supporting two people to eat at the same time. We saw one staff member take a glass from one person's hand and reposition them at the table in their wheelchair. This was done without checking with the person if this was okay to do. A senior member of staff told another staff member not to `feed` the cabbage to a person as this was difficult for them to swallow. When we checked we found that the person`s care plan detailed that they were on a normal diet. The kitchen staff told us the person was on a normal diet so it was unclear why they were not allowed the cabbage, why it was on their plate if they could not eat it and if the person had difficulty swallowing why this was not known by staff.

Not all the people in the home were supported to receive a healthy and balanced diet. We found that people who were at risk of malnutrition did not receive fortified foods. The requirement was detailed in care plans, on nutritional audits and care staff told us it happened. However, kitchen staff told us that they did not fortify foods but some people had milkshakes.

Records for people's food and fluid consumption were not always accurate. For example, we noted that a person had dropped their breakfast on the floor. A staff member came and cleared it and did not record that the person had not eaten their breakfast. In addition, staff completed charts at times hours after the event which meant the quantity recorded may be wrong. For example we looked at food and fluid charts for people and found that the night staff had completed these up to 07:00 am. We found that all previous days

were completed however when we checked the charts again at 10:10 am we found that these had not been completed for people since 07:00am. A senior member of staff told us this was because staff were still busy with offering people personal care and that charts would be filled in by 10:30 retrospectively. This meant that the documentation was not completed at the time when people had dinks and food and may not been a true reflection of their intake. We asked one staff member about this and they told us that they knew what had been given to people and they would sit and confirm with people what they had consumed. We saw the staff member complete this process, however not all people were able to accurately inform staff about what they had consumed because of their varying level of confusion or dementia. Where people's fluid intake was recorded, there was no guidance for staff to know what a person's optimal consumption should be. In addition, most charts we viewed did not have the fluid consumed tallied to confirm that the person had enough to drink.

One person told us there was no tea trolley coming around anymore for them to have snacks and hot drinks between meals. Staff told us they gave people drinks and snacks, however on the day of the inspection we only saw people who were in the main reception area enjoying activities having hot drinks between meals and people who asked for drinks. Records did not evidence that snacks were given to people although some people`s care plans had instructions from dieticians to ask staff to provide these.

We found that previous concerns had been identified by the clinical commissioning group (CCG) regarding how staff managed people`s nutrition when they received this via PEG`s. They had identified that staff did not contact people`s dieticians when they lost or gained weight and where dieticians were involved in people`s care staff had not always followed their guidance.

We found that although these concerns were communicated to staff not all the issues were actioned. People were not weighed weekly, they were not provided with fortified diets, staff were not completing food and fluid charts accurately and people continued to lose weight. We also found little evidence that people at risk of dehydration were encouraged to drink during the night when they were awake. We saw on food and fluid charts that drinks were recorded last given at 22:00 hours and next time in the morning by day staff at 08:00am. For example we observed one person in bed sleeping with their door wide open. Their mouth was dried and their tongue and lips were cracked.

We found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people`s nutrition and hydration needs were not always met.

The design and layout of the building enabled people who were physically able to move around the home. However, we noted that in one area of the home there was a slight ramp which when a person in a wheelchair independently went over this ramp, it caused a bump which the person nearly fell from their wheelchair.

We found that one of the units where people lived with dementia had different coloured front doors with knockers and letterboxes. Each door had the person's name and what staff could talk to them about. For example, one person could talk to us about crosswords, news and the army. There were plenty of places for people to sit; there was wallpaper on the walls of brickwork and floral print plus a fruit and vegetable stall and grass with picket fencing. On another unit where people lived with dementia the environment was not dementia friendly at all. There was nothing on the walls that reflected people's memories or past times. The colour of the walls were bland and not in line with current good practice guidelines regarding complimentary colours for people living with dementia. All the information was displayed in the written word and no signage or pictorial information was provided to help people find their way around the unit.

Some people's bedroom doors had numbers on them but no name or photographs. There were no memory boxes or memorabilia in the corridors or in the lounge areas to help stimulate people`s memory. Some people's rooms were personalised. However, some rooms were bare and other rooms looked over a cemetery. For one person who spent all of their time in bed, in pain, consideration needed to be given to how the provider could make this view more enjoyable and help to maintain the person's wellbeing. For example, with flowers, window art or attractive window dressings. One room had a very stained blind and a broken radiator and these were in need of attention. This was an area in need of improvement.

People told us that they received good support with their health care needs. The provider employed a team of physiotherapist, occupational health therapist and speech and language therapist to ensure that people with assessed needs for these services could access these on site. People told us they had support from the provider`s physiotherapy team and GP. One person told us, "The Doctor comes in regularly to see to my legs". One physiotherapist told us they supported people who were funded for physiotherapy and they achieved good results. We saw that people had input from the GP weekly, SALT, dietician, TVN and others. However we found that staff had not always followed these professionals advice as stated previously in the report. This was an area in need of improvement.

Requires Improvement

Is the service caring?

Our findings

People had mixed views about staff and if they were kind and respectful towards them. One person told us, "Yes, staff are kind and caring." Another person told us, "Staff are not caring, but those two [pointing towards two staff members] are okay." A third person said, "It's not bad here, staff do their best for me." One relative said, "The majority of staff are excellent and quite dedicated."

People who were more physically able, independent and able to engage in conversations were positive about staff and told us that their dignity was promoted. One person told us, "[Staff are] very good with privacy and dignity." However, other people who were more frail and dependent on staff were seen to have very little interaction or kindness shown. We found and observed that people had not received their care in a way to promote their dignity.

We observed that people were not always spoken with or reassured during care tasks or when they were assisted to eat. We heard a person screaming in their bedroom. We listened outside the door very closely and staff did not speak with the person. We knocked so we could check that the person was safe and staff opened the door and we noted that the person was receiving personal care, however staff were not giving any reassurance to the person.

We observed a staff member during meal time in a dining room asking a person why they were not eating. When the person said, "I don't know." The staff member who asked the question and another staff member started to laugh at the response. This did not show respect for the person. One person told us, "Staff don't listen with respect."

We observed one person supported by two staff members from their bed to a wheelchair. The two staff members told us that we could go in the room however they did not think to ask the person if they minded us being there. There was little communication with the person and staff did not give them the time to prepare or actively participate in the task. Staff did not communicate or give reassurance to the person and they did not consider the person`s feelings and dignity when they carried out the transfer. The way staff carried out the manual handling was not in line with safe practice and presented a risk for the person to sustain injuries.

We observed two staff members on a different unit use a full body hoist with one person in the lounge. They completed the whole task without any interaction, support or conversation with the person they were hoisting. They offered no reassurance or compassion and failed to maintain the person's dignity, by adjusting their clothing during the transfer.

We found that across the home staff were not always protective of people`s dignity. We observed one staff member leaving a person's room and as we walked by the room, we saw the person sitting on the toilet. The staff member had not protected this person's dignity and left their doors open so they could be seen in an un-dignified position by anyone walking past their bedroom. We spoke with a senior staff member on the unit who addressed this issue with the staff member.

However we found that none of the staff members in senior position in the home or the provider`s visiting senior management team addressed these issues with staff on the day of the inspection. For example we saw people who were not able to communicate or were not aware of their surroundings had not had their dignity protected. Bedroom doors being open meant that we could see from the corridors that people`s catheter bags were fully visible, on some people`s walls there were photos with them demonstrating for staff how they should be positioned. Doors were left open when people had their PEG feeds. We also saw a person early in the morning with their door open and them sitting in their chair without any clothes on just a towel around their private areas.

Care notes, including those with photos of a person's bottom were left out in bedrooms and care plans were not always stored in a locked cupboard. This meant that sensitive information may have been accessible to those who were not authorised to access them.

We found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not treated with dignity and respect.

Some people told us they felt staff listened to their views; however some people felt that staff had not listened to them. One person told us, "Yes, I feel I have a voice and staff listen to me." Another person said, "Don't feel like I have a voice and not listened too [by staff]. Just because my body don't move don't mean we are brain dead." Another person told us that they felt uncomfortable in their bed. They told us that an engineer had been to check the mattress and stated it was working. However, the person said, "The mattress is hard, it hurts my back." This indicated that although the mattress may have been functioning, there had been little consideration for how they were feeling and their comfort. Although they voiced their need this had not been resolved. A third person told us staff did not know them well enough to anticipate their needs. They said, "The care is not bad at all but they don't anticipate when I need the toilet."

Although some people were able to voice their needs and feelings we saw little evidence that staff took account and listened to people. For example in one person`s care plan there was a note for the night staff that the person was not an early riser and not to wake them up early. One staff member who had attended to the person just after 8am told us that they wake people up for breakfast as breakfast was between 8am and 9am. This meant that people's preferences were not always respected by staff.

People told us that they felt that agency staff were not as good as permanent staff and they felt that there were not enough staff to meet their needs in a caring way. One person said, "I'm fit and well, the staff are very good, but the agency ones are not so good." Another person said, "The agency staff don't know me." A third person said "I'm normally looked after okay but sometimes there's not enough staff." One relative said, "At lunch time, the staff don't have enough time to take my [relative] to the toilet; but [person] is looked after well, it's fine here."

We saw that where people`s needs changed this was often identified by visiting professionals and not staff. For example a person who lost a significant amount of weight had been identified by a visiting professional who asked staff to refer the person to a dietician. We had to ask staff to request a visit from the GP to review a person`s pain management.

Some people and where appropriate relatives of people told us they knew about their care plans and they were involved in reviewing these. One person told us they had reviewed their care plan two weeks before. Another person told us they knew they had a care plan but not seen it. One relative said, "I know of my [relative`s] care plan and I've checked it." However, some people told us they had not seen their care plans for a long time and they had not reviewed it. One person said, "Not seen my social worker and not had a

review in two years." Another person told they were not sure when their care needs were last reviewed.

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving care and support which met their needs and took account of their preferences.

People told us that they could have visitors when they wished and there were no restrictions in place. People who were able to socialise in the home they told us they enjoyed developing relationships with other people in the home and spent time together. One person said, "We got a little family here…..we all look after each other."

Inadequate

Is the service responsive?

Our findings

We found that the provider's systems and processes had not ensured that people received care and support in a personalised and caring way or that people's voices were always listened to by staff who supported them. People did not always receive personalised care and this was delivered in a task led way. Care was not always based on individual wishes, needs and choices. Some people told us that they were waiting for long periods of time for the toilet and pressure care was ineffectively managed. Records regarding the care and support provided were not always accurate. For example, we observed some repositioning records inaccurately recorded the position people were lying in.

People's care plans did not include the necessary information for staff to understand their needs and health conditions to be able to respond and meet people`s needs in a timely way. Care plans we reviewed contained negative language For example having a section called 'Problem area' 'and 'Episodes of aggression'. For one person their care plan repeatedly stated that the person's 'ability to communicate may fluctuate due to confusion', the person was 'not orientated to time and space' and 'has a diagnosis of dementia' with little specific guidance for staff to follow to help ensure effective communication. No reference was made to sensory needs of the person at all.

Staff were not able to tell us what people liked, disliked and their needs. We noted that some staff had a language barrier and did not always understand what we were asking them. This would have had an impact on communication with people who were less able, had limited communication skills or had a cognitive impairment.

None of the people`s care plans we reviewed contained any information regarding people's preferences for how they wanted to receive personal care or guidance for staff to support them effectively. We observed staff in the morning working their way from room to room and not necessarily considering people`s preference. Some people who were more able told us that they could get up when they wanted, however we saw that this had an impact on people who were less able and could not express their wishes or ring for assistance.

Some care plans we reviewed had not addressed all the health conditions people were diagnosed with and where care plans were in place these were sparse and did not provide staff with sufficient guidance on how to meet people`s needs. These areas included management of PEG sites, planning for people's mental health, tracheostomy care and infection control for communicable infections.

For example one person lived with a medical condition that can be life threatening. There was little evidence that consideration had been given to how the person should be supported with this. People with this illness can be stigmatised, subjected to prejudice and so sensitivity was required in discussions regarding the care and support they received. None of the care plans for the person gave any specific guidance as to how staff should support the person with this need other than to state the diagnosis. The care plan had no reference to if the person or their representative had agreed for the diagnosis to be included in the care plan.

The person had section titled 'This is Me' in their care plan. This was meant to contain personal information that informed care staff about the person's life history, interests, hobbies, occupation, relationships, pets and significant life events and achievements. This section did not contain any information about the person that could help staff understand them. We talked to nursing staff on the unit and they were able to talk about the person's physical health needs and diagnosis but were not able to give any other personal information about them.

Another person's care plan had a biography document that was completely blank, all consent forms were also blank and the 'This is me' document contained no person-centred information about the person. The person had a prolonged disorder of consciousness and the care plan stated that the person was 'unable to communicate needs due to condition'; however there was no guidance for staff to help ensure that they were communicating with the person in a sensitive manner. This person had a hospital acquired infection and although this was stated as a diagnosis in their care plan there was no mention of this or guidance for infection control measures to be followed by staff when supporting the person with personal care, or any other guidance regarding this need.

Care plans were not up to date and were not reflective of people`s current needs. For example one person`s care plan detailed that they walked with their rollator frame and staff told us they now used a wheelchair to mobilise. Care plans we saw recorded little changes in people`s needs since they had been admitted into the home and staff recorded `no change` in people's reviews in some cases for over a year. For example one person's nutritional care plan update recorded that they were on a normal diet and there was no change recorded in the care plan since 28 October 2016. However we found letters from a dietician and weight records which evidenced that the person should have been on fortified food due to weight loss and were having additional supplements to help them gain weight.

Nursing staff we spoke with told us that they found the care plans confusing and lacking in detail, they had noticed that plans were regularly reviewed but continuously stated 'no change'. They also told us that sometimes the home used agency nurses and although they aimed to use regular agency staff this was not always possible and agency nurses were unfamiliar with people`s needs. Given the lack of detail and specific guidance for supporting people in care plans it was difficult to see how an agency nurse would know what care to provide to people.

We saw that some people's nails were dirty and those people who were frail had not received oral care in some cases and their mouths were very dry. For example one person had an oral care chart in place for staff to record daily mouth care. We found that since the 01 December 2017 staff recorded `refused` daily, however there was no action taken or records in other notes to suggest that staff took any other action regarding this. We saw that this person`s mouth and lips were dry and did not look clean.

There were some records of people or their relatives signing consent forms but no reference to the content of the plans or involvement in planning care needs. Plans contained little information about people's likes, dislikes, preferences, cultural needs and life histories. When asked, staff were unable to tell us about people's preferences and wishes. We asked a staff member if a person came out of their bed and spend time in the lounge. The staff member said, "No because it's not safe for [them] they will fall so have to stay in bed." We reviewed the person's care plan and looked for a DoLS application for this. However, the care plan stated that the person was in bed due to chronic pain and not to stop them falling. This information was not communicated effectively so that every staff member supporting this person was aware of why the person stayed in bed.

Some people living in the home had different cultural backgrounds, however care plans were not developed

around this need and staff were not always knowledgeable if people required support to have their cultural needs met. However in some instances staff were able to tell us how they met people`s needs and preferences. For example staff told us about one person who was a vegetarian and how they ensured they offered choices to the person to support this.

People who were able to participate fully and attend the communal areas received opportunities for engagement. One person told us "I join in with the singing." Another person said, "I like the activities and the outside trips." A third person told us, "They [staff] give me exercises to do in bed." There was a singer in the building on the day of inspection and posters around the home about events and activities for December. On one unit there was an activity staff allocated five days a week. On the day of the inspection they played a game of snap with four people for the first part of the morning and then returned again after lunch to make cards with the same four people. They interacted well with the people who were engaged in both these activities and this staff member appeared to know each person well. We saw one person become agitated and the activity worker supported them to calm down in a calm and caring manner.

There were various activities and lifestyle programs advertised throughout the home with opportunities for people to be involved with. There were regular trips, regular visiting entertainment and activities provision seven days a week including some evenings and early mornings when this was suitable for people. Activity notices were displayed within the main lobby of the unit and also throughout the service. There were also photos of past activities that people had taken part in which included hat making and a sing a long sessions. A Christmas programme was displayed around the home and posters with provided activities and upcoming entertainment.

However we found that for those people who spent most of their time in their room or those who had limited communication skills, there was very little in the way of interaction or stimulation. One person told us, "I don't get out much, only once a week. I would like to go out more." Another person said, "Staff don't take me out. My [relative] does once a fortnight." When we spoke with people to find out how they felt living in the home one person got upset and started crying. They said, "I feel neglected." One member of the provider`s management team comforted the person until they had calmed down.

For one person activities had only three entries of 'taking a newspaper around in the home' in almost two months with no other activities noted. This was the same for most people in their rooms. One person's 'social care needs' care plan was vague detailing that the person had an interest in 'Listening to radio, watching television and reading the bible'. There was no information to give staff an idea about how to attempt to engage the person in an activity or conversation. An attempt had been made by the service to find out what people enjoyed and notes stating 'I like sewing' and 'I like music' were attached to people's doors but we saw no records evidencing that this had taken place for people. We asked a staff member about a person we had been monitoring and they told us, "I think she is lonely, I try and spend time to have a chat but we don't always get the time."

Following the inspection the provider told us about the various projects run by the registered manager. These included `wish come true` campaign, `Forest of Stars`- which is the use of a tool to enable managers to achieve best practice based on proven results and others however we were not given evidence on how this improved the care people received. The provider also told us that Forest Care Village achieved the new Stroke Association accreditation in order to embed this specialism in the home, however we saw no evidence of how this benefitted people in the home.

End of life care was provided for people by the service. However, care plans were sparse and did not include pain management that may be needed, people's wishes or religious arrangements. There were no records to

evidence that conversations were held with people`s families in case people were unable to communicate their needs and gather information about them to make their remaining time pleasant and comfortable. The lack of planning and robust monitoring did not ensure people died a dignified and pain free death.

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people`s needs and preferences were not always assessed and care plans were not developed to meet all their needs in a personalised way.

People told us they were aware of how to complain. One person said, "I know to go to the unit manager if I want to complain." Another person said, "I put my concerns to the unit manager." A relative told us, "Concerns are dealt with quickly." Complaints were looked into by unit managers and the administrator held a log of complaints received. We noted for those we viewed that the unit manager had investigated concerns. For example one person reported to the unit manager about an issue they had with a staff member. We saw that the unit manager had addressed this in a meeting with the staff.

We saw that information and guidance about how to make a complaint was displayed at Forest Care Village. Before the inspection we asked the provider to share with us a response to a complaint. We saw that the response had been adequate and followed the provider`s policy.

There were opportunities given to people and their relatives to feedback on the service they received. We saw a recent survey carried out by the provider and people who responded were positive about the care and support they received.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service on 30 November 2016 we found that the service was meeting the required standard. Prior to this inspection we received numerous concerns from family members of people who used the service, staff and the local funding authorities regarding the quality and safety of the care and support people received.

We found that not all the people living in Forest Care Village received care and support in a safe and effective way. There was a significant difference between the care and support provided for people who were clearly able to communicate their needs and wishes to staff and people who had higher care needs and were unable to make their wishes known. The quality audit systems in place were not effective and had not identified and resolved the issues found in the inspection.

The provider had a management structure in place which consisted of unit managers, clinical lead, team leaders and a registered manager. They also operated a management on-call system for staff to have this support any time they needed including nights and weekends. The units were led and managed by unit managers who were overseen by a clinical lead. During the inspection we reviewed the weekly manager meetings and heads of department meetings minutes; however, the registered manager was not recorded as being in attendance at these meetings. Following the inspection the provider submitted evidence of four meetings between June 2017 and September 2017 where the registered manager was present. Some people told us they did not know the registered manager, they only knew the unit managers. Staff gave us mixed views about the registered manager being visible around the home. Some staff told us they saw the registered manager regularly walking around the units; however other staff told us they rarely saw them.

The registered manager told us they collated information from each unit weekly and monthly and analysed this. They shared with us the monthly Key Performance Indicator (KPI) report which they sent to the provider with the collated data and assessments of how well the service was performing. This report provided numbers of falls occurring in current month versus previous month, number of pressure ulcers, number of safeguarding, complaints, environmental issues and other areas; however these were not detailed and only offered numerical data in most cases. Actions for addressing these areas were generic and not specific. For example where people had developed pressure ulcers the names of people were not provided and the action referred to a separate report. We asked several times during the inspection for all the evidence to demonstrate effective monitoring however the registered manager told us they had no other evidence and did not make these 'separate reports' referred to in the Key Performance Indicator (KPI) reports available to us.

The registered manager told us that they relied on the data they received from the units when they completed their monthly report. We found that the units completed their own audits, analysis and management of complaints. However, we found that the systems were inconsistent across units and not all unit managers followed the same structure, process or format. Some units had an index which listed all the areas the managers had to check monthly where others did not have a clear system and audits were just filed in one folder and not carried out regularly. Some units had audits completed recently, others did not.

For example, one unit had an infection control audit last completed in 2016 where other units had this completed monthly. However, where audits were completed and action plans developed, there was no system for checking actions were completed and we were unable to find examples of completed actions. For example, we found care plan audits completed for some people on one unit. These were hand written hardly legible and the identified gaps in peoples' care plans were listed under required actions, however these had not been signed off to indicate they were completed. The provider also shared with us an action plan developed following a meeting in September 2017 where numerous concerns were discussed. Actions were needed from unit managers to address poor documentation, risk assessments needed to be updated, people`s care plans had to be reviewed, daily walk rounds by the clinical lead and other actions. These actions were signed off in November 2017 as completed however we found that all these issues were still present at the time of the inspection.

Falls audits collated the number of falls over a period of a month for each person and listed actions in response to each fall. However although the information was available on the number of falls the actions were just immediate response like emergency services called, GP visit or monitor closely. The analysis of the audit did not give consideration of further preventative actions to be taken to prevent reoccurrence. The registered manager when we asked was unable to give us an overview of all the falls occurring in Forest Care Village and demonstrate how they analysed these to look for trends and patterns. For example, when we analysed an audit from one unit we found that the majority of falls in November 2017 occurred in people`s bedrooms and between 2pm and 8pm. There was no reference that the unit manager or the registered manager assessed staffing at this time or considered environmental factors like lighting in order to help mitigate further the risk of falls for people.

Separate weight and skin integrity audits were carried out by the unit managers. The weight audits looked at each person`s weight from June 2017 to November 2017. The audit gave reference to how much weight people had lost in a period of two months and listed the actions in place to promote good nutritional intake for people. However we found that the actions referred only to existing measures in place such as staff monitoring food and fluid intake, previous referrals to dietician and that the person was on a supplement. There was no consideration to implementing new measures to encourage people to eat. For example one person lost 1.1kg from September 2017 to October 2017 and further 1.8kg from October 2017 to November 2017. The actions listed were `monitor intake and encourage person to complete meals'. The audits had also not led to further action being taken where people continued not receiving appropriate food and fluids.

The skin integrity audit collated information about people`s Waterlow score. The Waterlow score gives an estimated risk for the development of a pressure sore for people. The audit identified if people with high scores had pressure relieving equipment in place and if people`s skin was intact. However there were no actions identified to suggest that staff considered looking at people`s nutrition and diet in relation to their risk of developing pressure ulcers. We found that this separate monitoring systems were not analysed together to enable staff to implement preventative measures for people who were identified as losing weight and therefore at increased risk to develop pressure ulcers. For example a person who lost 4.7kg since September 2017 had a normal mattress in place not a specialist mattress to prevent the development of pressure ulcers. We found that this was the same for another three people just on one unit. This meant that the care and support people received was not effective in preventing and protecting them from the risk of harm.

We found that people`s care plans were not up to date, were extensive and contained conflicting information about people`s needs and were not effectively reviewed. Care plans had not addressed all identified needs for people. We found examples where people`s care plans had not changed since they moved in the home and updates suggested there were no changes to note for people. However we found

that some people`s needs changed significantly they lost weight, and developed swallowing difficulties, however this was not evidenced in the care plans. This had not been addressed through the provider's quality monitoring systems.

There was a tool available for staff titled 'Daily spot checks-behind closed doors'. This was to be completed to check on the standard of care people received, their safety and welfare. However, there were very few records of these being carried out.

There was a call bell audit completed on some units to test the length of time bells rang for. However, some people told us that often when they rang their bells staff turned them off without delivering care and they had to wait until staff returned to them. Therefore the audits were not a reliable indication of how long people waited for assistance.

We asked the registered manager to provide us with evidence that they had an effective system to monitor the quality and safety of the care and support people received. We asked if they had any evidence that they had an overview of the service. However all the quality assurance documents and meeting minutes they provided for us were carried out by other members of the team. Supervisions for unit managers were completed by the clinical lead and unit managers completed supervisions on their units. The quality monitoring systems in place had not been effectively used in identifying concerns and areas of risk. The provider had not identified the concerns that we found during our inspection and had therefore not taken action to mitigate risks or ensure people received safe and effective care. The provider shared with us an action plan they put in place in September 2017. Actions listed were signed off as completed in November 2017 however, we found that all the issues were still present at the time of the inspection and improvements had not been made. For example risk assessments and care plans were not up to date. This meant that the quality monitoring had not led to sufficient improvement.

We found that due to the ineffective quality assurance systems used and the lack of effective monitoring people suffered harm, they developed pressure ulcers, were placed at high risk of choking, and they had not received person centred dignified care and support.

Therefore we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as their governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved.

Before the inspection we received concerns from one person who told us that they feared repercussions if they raised concerns with the manager. During this inspection other people reported concerns to us under anonymity as they also had a fear of repercussions if they openly complained.

There were surveys completed to obtain people's voice and some units had resident and relative meetings. However, we saw no action plans developed as a result of people's feedback. We also noted that for people who were unable to express their view, or for those who did not want to speak up, there were no observations carried out by managers to understand what people's care experiences may be like. The recent survey carried out by the provider collated feedback from people, relatives and staff about the quality of the service provided and we saw that these were mainly positive. Following the inspection the provider told us about the various projects run by the registered manager aimed at promoting best practice however we were not given evidence on how this improved the care people received.

Following this inspection we received an immediate action plan from the provider which addressed some of the concerns we had raised with the registered manager in feedback following the inspection.

We received feedback from the local funding authorities who carried out reviews of the people living in Forest Care Village. They told us that the provider had put immediate actions in place to help ensure the care people received was safe and developed a more detailed action plan to address all areas of concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People`s needs and preferences were not always assessed and care plans were not developed to offer staff guidance in how to meet people`s needs in a personalised way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People`s dignity and privacy was not always promoted by staff. People did not receive care and support in a dignifying way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The decisions taken in people`s best interest could not be evidenced that there were made following the best interest process and staff carried out care and support without asking people for their consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People`s nutrition and hydration needs were not always met.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people`s well-being were not sufficiently mitigated to protected them from harm.

The enforcement action we took:

We issued an Urgent Notice Of Decision to restrict admissions in Forest Care Village and imposed positive conditions to help the provider make the necessary improvements.

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 There were ineffective systems and processes established to protect people from improper treatment and support.

The enforcement action we took:

We issued an Urgent Notice Of Decision to restrict admissions in Forest Care Village and imposed positive conditions to help the provider make the necessary improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider`s governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved.

The enforcement action we took:

We issued an Urgent Notice Of Decision to restrict admissions in Forest Care Village and imposed positive conditions to help the provider make the necessary improvements.