Shaw Healthcare Limited

Forest View

Inspection report

Southway
Burgess Hill
West Sussex
RH15 9SU

Tel: 01444245749
Website: www.shaw.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30 and 31 October 2017. The first day of the inspection was unannounced, however the second day of the inspection was announced and the registered manager, staff and people knew to expect us.

Forest View is a residential service providing accommodation for up to 60 older people, some of whom are living with dementia and who may require support with their personal care needs. On the day of the inspection there were 59 people living at the home.

Forest View is situated in Burgess Hill, West Sussex and is one of a group of services owned by a national provider, Shaw Healthcare Limited. It is a purpose built building with accommodation provided over two floors which are divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. There are also communal gardens. The home also contains a day service facility where people can attend if they wish, however this did not form part of our inspection.

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

We previously carried out an unannounced comprehensive inspection on 14 July 2015 and the home received a rating of 'Good'.

At this inspection, people were provided with sources of entertainment and stimulation through planned group activities and external entertainers. One person told us, "There's plenty to do. I like the Bingo and music. I like watching my TV". Some efforts had been made to provide more meaningful activities for people that were based on their hobbies and interests before they had moved into the home. For example, a knitting club had been introduced which a small number of people enjoyed. However, in the main, there was a lack of meaningful occupation and stimulation to occupy peoples' time and staff did not always have sufficient time to interact and engage with people.

Peoples' needs and preferences were assessed when they first moved into the home and on-going reviews took place to ensure that the care people were receiving was meeting their current needs. Care plans were person-centred, however, although relatives were informed of any changes or updates in peoples' care, feedback from them was that they were not always involved in the on-going reviews that took place and that sometimes they were not provided with sufficient explanation about any changes in the care their relatives received. When this was raised with the registered manager they told us that this was something that they wanted to improve and develop.

The staff team consisted of permanent staff as well as the use of temporary staff to ensure that the home

was sufficiently staffed to meet peoples' physical care needs. However, the skills and level of understanding of the temporary staff differed to that of the permanent staff. Measures had been taken to ensure that temporary staff worked alongside more experienced staff to enable the sharing of knowledge and skills. Nevertheless, temporary staff lacked understanding about the content of peoples' care plans and information that was specific to their care needs. A comment by a healthcare professional echoed this, they told us, "We feel that there is in general poor communication to staff and that information about people isn't shared effectively".

The provision of activities to promote more meaningful occupation for people, the need to ensure that there is an increased level of interaction, staff engagement and stimulation from staff to support people to participate in pastimes that they enjoy, as well as the need to increase the involvement of people and their relatives in the on-going review of peoples' care, are areas of concern.

Regular audits of the systems and processes within the home and of the care people received, took place to ensure that people were receiving the type of care they had a right to expect. When improvements needed to be made these were highlighted and timely action taken to ensure that things improved. However, although effective in most areas, this had failed to identify the shortfalls in practice that meant that people were not always supported in a person-centred way.

People, relatives and healthcare professionals told us that staff were kind and caring and observations showed that some positive relationships had developed. Comments from relatives included, "I think the carers are amazing, so patient. It gets a thumbs up from us. It has a good reputation out and about" and "We are happy for my relative to stay here. The carers are professional and dedicated, wonderful". A healthcare professional told us, "Some staff are excellent and take a very proactive approach to care. They recognise individual peoples' needs and endeavour to provide the best possible care".

Peoples' consent was gained before supporting them. The registered manager was aware of the legislative requirements when a person lacked capacity and had worked in accordance with these. People were treated with respect and dignity and their right to privacy was maintained. Staff were aware of the importance of supporting people in a sensitive manner and information that was held about people was kept in locked cabinets to ensure that confidentiality was maintained. People, dependent on their needs, were able to stay at the home until the end of their lives. Plans to ensure that people received good end of life care were in place and records and observations showed that peoples' wishes and needs were respected at this time.

People told us that they felt safe, comments included, "Yes I feel safe; I can lock the door if I want" and "I feel safe here, more than I did at home". Risks to peoples' safety were regularly assessed and appropriate care was provided to ensure that people received safe care. People were able to take risks and observations showed people independently walking around the home using their mobility aids. People were protected from the risk of harm and abuse as they were cared for by staff who had undertaken the relevant training and who knew what to do if they were concerned about a person's welfare. People had access to external healthcare services if they were unwell as well as having access to medicines if required. People and relatives told us that people were happy with the food that was provided, that they enjoyed the meals and were provided with choice. Comments included, "You tell them what you want, there's sandwiches in the evening. There's plenty of drinks" and "It's very good".

People and relatives were able to share their views and ideas through regular residents' and relatives' meetings as well as annual surveys and actions had been taken in response to peoples' feedback. There was a complaints policy in place and complaints had been dealt with in a timely manner. People, relatives and

staff were complimentary about the leadership and management of the home. Comments from staff included, "The manager is very approachable", "I think things have really improved since the manager came. Everyone works well as a team" and "I've worked in a lot of care homes and nursing homes and this is by far the best. It's a very warm and friendly place and the management have a lot to do with that". There was a friendly, welcoming atmosphere and people and staff appeared at ease. Staff were encouraged and able to share their views and were kept informed about changes that occurred within the home through regular handover and staff meetings.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe.

There were sufficient numbers of skilled and experienced staff to ensure current numbers of people living at the home were safe and cared for.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety. Risk were identified and monitored and there were assessments in place to ensure peoples' safety.

People had access to medicines when they required them. There were safe systems in place to manage, store, administer and dispose of medicines.

Is the service effective?

Good

The home was effective.

People were asked their consent before being supported. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity and had worked in accordance with this.

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. This included people at the end of their lives as people were able to plan for their end of life care.

Is the service responsive?

Requires Improvement

The home was not responsive.

Although care plans were detailed staff did not always have knowledge of the contents of them. There was a lack of involvement and relatives in the planning and on-going review of peoples' care.

People had access to activities. However, there was a lack of meaningful occupation and person-centred stimulation for people to participate in.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Quality assurance processes ensured the delivery of care and drove improvement. However, had sometimes failed to recognise the shortfalls in peoples' care.

People, relatives and staff were complimentary about the leadership and management of the home. The registered manager maintained links with other external organisations to share good practice and maintain their knowledge and skills.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Forest View

Detailed findings

Background to this inspection

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

The first day of inspection took place on 30 October 2017 and was unannounced. The inspection team consisted of two inspectors and two Experts-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection took place on 31 October 2017 and was announced. The inspection team consisted of two inspectors.

Prior to this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the registered manager had submitted. A notification is information about important events which the provider is required to tell us about by law. We used all of this information to decide which areas to focus on during our inspection. On this occasion we had not asked the provider to complete a Provider Information Return (PIR) prior to the inspection, this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make.

During our inspection we spoke with 19 people, 10 relatives, 11 members of staff and the registered manager. Prior to the inspection we had contacted a professional from the local authority to gain their feedback. Subsequent to the inspection we contacted three healthcare professionals who often visited the home. Some people had limited or no verbal communication and were unable to speak to us. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records about peoples' care and how the service was managed. These included the individual care records for nine people, medicine administration records (MAR), four staff records, as well as records for temporary staff that sometimes worked at the home, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounges and in peoples' bedrooms. We also spent time observing the lunchtime experience people had and the administration of

medicines.

The home was last inspected on 14 July 2015 and received a rating of 'Good'.

Good

Is the service safe?

Our findings

People and relatives told us that Forest View was a safe place to live. When asked why they felt safe, comments from people included, "Yes I feel safe, I can lock the door if I want", "I feel safe here, more than I did at home", "I feel very safe here, they are all my friends" and "The staff are pretty good as a rule, there is always someone to help". This was echoed by a comment provided by a relative, who told us, "We feel they are safe, we have had no issues".

There was mixed feedback with regards to the sufficiency of staff. One person told us, "They are good at coming to answer the bell and they are nice to me". Another person told us, "The call bells are answered quickly; I've never seen people move so fast. They will come in from other units". However, one relative told us, "I'm not so happy with the staffing; it sometimes takes a while to get extra staff to help with care". Observations showed that on most occasions there were sufficient staff to meet peoples' needs. There were two members of staff allocated to each unit, apart from one, which was staffed by one member of staff and was home to people who had been assessed as having less dependency on staff support that people living in the other units of the home. In addition, there was a team leader allocated to oversee each floor of the home. Records of staff rotas showed that this was a consistent level of staffing.

All but one unit was designed in such a way that, although self-contained, could be opened up to create an open-planned space so that dining and living spaces could become shared, communal spaces. This meant that staff from other units could monitor peoples' safety within the communal areas if two members of staff were required to support a person away from the communal space within their unit. One unit, which accommodated people who had been assessed as having lower dependency levels than the rest of the home, had one member of staff. Although most observations showed that this was usually sufficient to meet peoples' needs, there were times when people had to wait for support due to the level of staffing. For example, one person required the use of a hoist to support them to move and position. The providers' policy states that two members of staff are required to operate hoists to ensure peoples' safety. This meant that the person had to wait for an additional member of staff to become free so that they could assist the member of staff and support the person to move and position. When this was fed back to the registered manager they acknowledged that this occasionally created a delay, however, explained that there was usually staff from other units, or the management team themselves, that could be called upon to assist the member of staff if this was required. This was echoed in a comment made by one staff member who told us, "It's fine, we can always get help from another area if we need to".

The provider had engaged in an on-going recruitment programme to recruit more permanent staff, however, in the interim period had ensured that there was sufficient staff to meet peoples' needs by using temporary staff. Peoples' individual needs were assessed prior to them moving into the home and these needs were looked at alongside the needs of existing people who lived at the home to ensure that staffing levels could meet peoples' assessed level of need. Peoples' needs were regularly assessed and used to inform the staffing levels. The registered manager told us that existing staff often worked additional hours and that staff, who had other roles within the home, also worked as care staff. They explained that this helped ensure that staffing levels were flexible to meet peoples' needs as there was always staff, temporary and

permanent, that they could call upon if peoples' needs changed and additional staffing was required.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. There were further checks to ensure that temporary staff, who often worked at the home, were suitable to work with vulnerable groups of people. The registered manager had obtained information from the agency that employed the temporary staff to assure themselves that suitable checks had been carried out. The registered manager told us about a situation where a new temporary member of staff was unable to start work until such records were received from the agency they were employed with. This demonstrated that the registered manager had a firm understanding of the importance of ensuring that rigorous checks on staffs suitably were carried out and implemented in practice prior to them having contact with vulnerable people.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training, could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace. One member of staff told us, "I have had to deal with a safeguarding issue here once. I reported it to the manager and they dealt with it really well. The person doesn't work here anymore". Another member of staff told us, "We do get training on our induction and every year afterwards. It's good and there are always changes".

Risk assessments for the environment, as well as peoples' healthcare needs, were in place and regularly reviewed. Each person's care plan had a number of risk assessments which were specific to their needs; these identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. One of the risk assessments had identified that one person had an increased risk of falls. Measures had been taken to ensure that the person was able to continue to be independent whilst minimising risk. The environment had been considered in relation to items that the person might trip on, as well as the footwear they wore, their sight and any aids they may need to ensure that they could see properly were also considered. When people had fallen, appropriate measures had been taken such as ensuring the person received medical attention when necessary and identifying the cause of the fall to minimise the chances of this reoccurring. For people who had multiple falls, advice has been sought from an external falls prevention team who had often confirmed that the measures that staff had already implemented were appropriate.

Accidents and incidents had been recorded and monitored to identify patterns and trends and relevant action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in peoples' needs or support requirements. Records showed that one person had fallen out of their bed. After discussions with the person it was agreed that their bed be moved so that one side of the bed was against a wall. This had had a positive effect and the number of falls the person experienced had decreased. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency.

People were assisted to take their medicines by trained staff that had their competence regularly assessed. The provider had implemented an electronic recording system for the management of medicines across all of their services. Staff accessed peoples' medicine administration records using a laptop computer and used

this to record when they had given people their medicines. Staff told us that this helped them to know when medicines were required and also identified the amount of medicines that were in stock to ensure there were sufficient stocks of medicines when people required them. Observations showed that safe procedures were followed when medicines were being dispensed and administered and peoples' consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. Records showed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

Good

Is the service effective?

Our findings

There was varied feedback about staffs' skills and experience, particularly in relation to temporary staff when supporting people who were living with dementia. People were cared for by permanent and temporary staff, with the majority having the relevant skills and experience to meet peoples' needs. People and relatives told us that they felt that staff were competent. However, a healthcare professional told us, "Some staff are very competent and others seem to be lacking in their knowledge, particularly of dementia and some of the associated care needs of patients with dementia". The registered manager was aware of the importance of acknowledging staffs' skills and abilities when allocating work to staff. When new or temporary staff were allocated to work with people, measures had been taken to ensure that they worked with existing, experienced staff, to ensure that they received appropriate support and guidance within their roles. People and relatives told us and our observations confirmed, that people were asked for their consent before being supported and that staff were patient and respected peoples' right to make decisions. One person told us, "The staff are very hard working, caring and patient".

The provider and registered manager demonstrated a commitment to learning and development. Staff that were new to the home were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures as well as an orientation of the home, an awareness of the expectations of their role and the completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. A member of staff, who had recently completed their induction, told us, "I had done something completely different before I came here and the induction was really good. I worked with other support staff until I felt confident".

Staff had completed training which the provider considered essential and this was updated regularly. The registered manager had developed links with external organisations to provide additional learning and development for staff, such as the local authority, Parkinson's' nurse, Dementia Crisis team, Dementia In-Reach team and the Living well with Dementia team. These teams provide advice, training and information for care homes that provide care to people living with dementia. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. One member of staff told us, "The training is good. I did some dementia training quite recently which was useful as so many people here have it". Some staff held diplomas in health and social care or were working towards them. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss peoples' needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive.

Peoples' communication needs were assessed and met. Observations of staffs' interactions with people showed them adapting their communication style to meet peoples' needs. People had access to relevant healthcare professionals to maintain or improve their communication, such as opticians and audiologists. We observed people wearing the spectacles and hearing aids that had been prescribed. Effective communication continued amongst the staff team. Regular handover and team meetings, as well as written

communication books, ensured that staff were provided with up-to-date information to enable them to carry out their roles.

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).

We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and staff had a good understanding of MCA and DoLS and had implemented this in practice. Staff explained that some people, who were subject to a DoLS authorisation, were unable to leave the home on their own and records showed that DoLS applications had been made to the local authority. There had been a delay in the DoLS being assessed and authorised by the local authority and in the interim period the registered manager had ensured that peoples' capacity was assessed for specific decisions that affected their lives. DoLS care plans had been implemented to ensure that all staff knew the limitations or the restrictive practices that were used as part of peoples' care. When people had been assessed as lacking capacity to make specific decisions themselves, the registered manager had ensured that they had involved relevant professionals in the person's care. This ensured that any decisions made on behalf of the person were in their best interests.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, Falls Prevention teams, District nurses, Chiropodists and a Parkinson's' nurses. It was apparent that existing staff knew people well and staff told us that they were able to recognise any change in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. Records showed that staff monitored peoples' healthcare needs and made timely referrals to GPs if peoples' health had deteriorated. Peoples' risk of malnutrition was assessed upon admission. A Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed regularly, to ensure that they were not unintentionally losing weight. Records for some people showed that they had been assessed as being at a higher risk of malnutrition and the registered manager had ensured that changes were made to the frequency in which the person was weighed so that they were monitored more closely. In addition, peoples' food had been fortified to increase their calorie intake. Food and fluid intake had been recorded to monitor what people were eating. Records of these showed that staff were provided with sufficient guidance with regards to the optimum daily amount of fluids people should have so that they knew when to report issues of concern if people had not had sufficient fluids.

Peoples' skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had pressure wounds, District nurses visited regularly and ensured that wound assessment charts had been completed providing details of the wound and the treatment plan recommended. Effective monitoring also took place to monitor for improvement or deterioration. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses.

People had a positive dining experience. Some people chose to eat their meals in the main dining area, whilst others preferred to eat their meals in their rooms and this was respected by staff. A relative told us, "My relative normally has their meal in the main room unless they are ill, then they have it in their room". People told us they were happy with the quality and choice of food available. One person told us, "You tell them what you want; there are sandwiches in the evening. There are plenty of drinks". Relatives were positive about the food provided, one relative told us, "I have had the food, it's very nice. My relative seems to like it". The dining environment created a pleasant setting for people to have their meals; tables were laid with placemats, napkins, cutlery and condiments. Adapted equipment was available for people to use to aid their independence, such as cups with handles and plate guards. People were able to sit with others and sometimes enjoyed conversations with one another as well as with staff. Observations showed people being asked if they would like additional servings of the puddings that were on offer and this was met with delight and shared smiles and humour between people and staff.

Consideration had been taken with regards to the layout and décor of the home to ensure that people, particularly those living with dementia, were able to navigate their way around the building. The home is spread over two floors and contains six, ten-bedded units. People could move about freely within the home and signage was in place to aid peoples' understanding and minimise confusion and disorientation. Some people had photographs, as well as numbers on their bedroom doors, to enable them to remember where their rooms were. Each unit had a name, these included Daffodil, Snowdrop and Buttercup. Efforts had been made to make the home more personalised and these unit names had been adapted to reflect street names such as Snowdrop Lane, Buttercup Mews or Daisy Walk. The home had been decorated to reflect peoples' levels of understanding. For example, most units were neutrally decorated and people were able to furnish their rooms with furniture from their own homes as well as items and belongings that were important to them. The lower floor, which was home to most people who were living with dementia, was decorated in a garden theme with murals on the walls reflecting garden scenes and flowers. This created more of a welcoming and softer atmosphere and helped to assist people to feel comfortable and less anxious. The registered manager had plans to improve the environment even further to promote more of an interactive and sensory experience. People had access to the communal gardens and there were plans to improve these further to increase the sensory impact and enable people to be more involved in attending to the garden if this was something they enjoyed.

Good

Is the service caring?

Our findings

People were cared for by staff that were kind, caring and compassionate. It was apparent that positive and warm relationships had developed between people and staff. People and relatives' confirmed that staff were kind and caring. Comments within a recent relatives' survey included, 'We have been very impressed by the way our relative has been looked after at Forest View over the past', 'Staff are friendly', 'I think the staff do a very good job and are always friendly and willing to do anything one asks' and 'Very happy with the care my relative receives'. When asked about the caring nature of staff, relatives told us, "I think the carers are amazing, so patient. It gets a thumbs up from us. It has a good reputation out and about" and "We are happy for my relative to stay here. The carers are professional and dedicated, wonderful". A healthcare professional told us, "Some staff are excellent and take a very proactive approach to care. They recognise individual peoples' needs and endeavour to provide the best possible care".

People were cared for by a majority of existing, permanent staff who knew people well. There were warm and friendly interactions between people and staff with smiles, laughter and banter. People told us that they liked staff and that they felt happy. Comments from people included, "They are nice staff, they know me", "They are nice here" and "Of course they're nice- polite. Always nice to you". Relatives were equally as positive. Comments included, "The staff are lovely, the medication lady gave my relative a kiss on their forehead", "I think the staff are first class, we have had no issues" and "I looked after my relative at home and now they live here. I'm very happy they are here and getting great care".

There was a friendly, welcoming and relaxed atmosphere. People were encouraged to maintain relationships with one another as well as with their family and friends. Observations showed people engaging in conversations with one another throughout the day and receiving visits from their friends or relatives. People told us that they were able to have visitors' to the home and that they were welcomed and our observations confirmed this. People were treated with respect by staff who took time to explain their actions and involve people in the care that was being provided. People's diversity was respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Individual person-centred care plans documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences.

People could choose how they spent their time, some spent time in the communal areas of the home, whilst others preferred their own space in their rooms or quieter areas of the home. Peoples' independence was promoted and encouraged. People were observed walking around the home using their mobility aids and choosing where and how they spent their time.

Peoples' privacy was respected and maintained. Information held about people was kept confidential. Records were stored in locked cupboards and offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. Staff were observed knocking on peoples' doors before entering, to maintain peoples' privacy and dignity. When

people required assistance with their personal care needs, staff attended to these in a sensitive and discreet manner.

People were involved in decisions that affected their lives. Records showed that people and their relatives had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to peoples' feedback or changes in their needs. Regular residents' and relatives' meetings were held, enabling people and relatives to be kept informed of information relating to the running of the home, as well as being able to share their feelings and opinions. Records showed that people had made suggestions about the refurbishment of the gardens and the laundering of peoples' clothing. A relative told us, "There is a residents meeting every two months. There were about 15 people at the last one". Relatives told us that they were kept informed of any changes to peoples' needs. Comments from relatives included, "They ring us if there are any problems" and "They ring to keep me updated, they rang and told me when my relative had fallen out of bed". Regular surveys to gain peoples' and relatives' feedback took place to inform the registered manager of peoples' wishes. The registered manager had recognised that people might need additional support to be involved in their care; they had involved peoples' relatives or social workers, when appropriate, and if required people could receive support from an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the home and were supported until the end of their lives. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

People told us that they had access to and enjoyed external entertainment and playing games of Bingo. Comments from people included, "There's plenty to do. I like the Bingo and music. I like watching my TV". However, despite this positive feedback we found areas of practice that required improvement.

Peoples' preferences and life histories had been documented in their care plans when they first moved into the home. However, it was not evident how this information had been used to provide meaningful and person-centred stimulation for people. There were two activities coordinators who supported people to participate in activities such as Bingo, colouring and painting. Observations showed small groups of people involved in pumpkin decorating and knitting as well as enjoying visits to the internal hair salon. External entertainers also visited the home to provide sources of entertainment for people. A relative told us, "The activities on offer are good; they have some great musicians visiting". Care records for one person contained information and an assessment which had been shared by an external organisation. Information which was pertinent to the person had been included, this detailed the person's hobbies and employment and provided suggestions of possible activities that the person might enjoy to encourage stimulation and decrease their anxiety. However, these had not been implemented in practice. Records to document the one to one time, as well as the group activities that people participated in, did not demonstrate that activities were meaningful or person-centred. When this was raised with the registered manager they told us that there were plans to improve the activities provision to make it more person-centred and meaningful for people. Plans included introducing a potting shed and raised beds in the garden for people to enjoy and rummage boxes containing different items that people could look through and hold. These would be shared between the units and rotated regularly so that people would be able to have different experiences.

The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for all people, particularly those living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Observations showed people spent most of their time sitting in armchairs watching television, sleeping or walking between one area of the home to another. Although there were sufficient staff to meet peoples' physical needs, staff were busy and were not always able to take time to sit and interact with people. Observations showed some existing, permanent staff, interacting with people and taking time to enjoy conversations with them. However, some staff, particularly temporary staff, did not engage with people and instead undertook task related activities. This sometimes created missed opportunities for interaction and engagement with people, as some people were sitting on their own without staff support. This was echoed within comments made by one person and a healthcare professional. The person told us, "They don't take time to get to know me". A healthcare professional told us, "Staff very task-focused. Lack of staff engagement in activities. Some excellent staff, but on the whole there is inconsistency across the care home, which we find concerning".

Care was centred on peoples' needs and abilities. Detailed care plans contained specific information about people, were person-centred and contained information on peoples' preferences and life histories. These helped to inform and guide staffs' practice and provided staff with an insight into peoples' lives before they

moved into the home. Observations showed that existing staff knew people well and engaged in conversations with people about their interests. Although detailed and specific, the contents of care plans and the guidance in place to meet peoples' needs, was not always known by staff. This was particularly apparent when temporary staff were asked about peoples' care or when they were observed interacting with people. A comment made by a healthcare professional echoed this. They told us, "We feel that there is in general poor communication to staff and that information about people isn't shared effectively".

Regular reviews of peoples' care took place to ensure that the care they were receiving was meeting their current needs. However, it was not evident if people or relatives had been involved in these reviews. People and relatives told us that they would go to the registered manager or team leaders if they had queries about peoples' care. However, there was mixed feedback with regards to peoples' and relatives' involvement in the on-going review of peoples' care. Care plan records showed that people had been assessed when they first moved into the home and that conversations with people and their relatives, if appropriate, had taken place to ascertain peoples' preferences. However, relatives told us that although they were always informed of any incidents or updates in peoples' care, they were not always asked their opinion about the care that should be provided. They also advised that when changes in peoples' condition and care occurred, these were not always fully explained to them so that they had an understanding of why specific courses of action were being taken. Out of the ten relatives we spoke to, two relatives, for two separate people, told us about some changes that were taking place for their loved ones and explained that they did not fully understand the reasons for this and that this had caused them anxiety and upset. When these points were raised with the registered manager, they explained that this was something they were keen to improve. Meetings had already been arranged for some relatives to ensure that any changes in the plan of care for their loved one was discussed and fully explained. The registered manager explained that they wanted to implement mechanisms where frequent, individual meetings and conversations occurred amongst people, relatives and staff to ensure that people and their relatives were involved in the process and had the opportunity to ask questions about peoples' care.

The registered manager had not ensured that the care and treatment of service users met their needs, was appropriate or reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Forest View is a care home without nursing. Regular, on-going assessments of peoples' needs took place to ensure that there was sufficient staffing and that their needs could continue to be met. Concerns that were raised to us, by relatives and healthcare professionals, as well as observations of peoples' care records showed that when peoples' needs and their dependency levels increased, the management team and staff were quick to highlight these changes. Relatives and healthcare professionals sometimes felt that this was so the person could be moved to another care home, due to the increase in their care needs. A healthcare professional told us that they felt that the provider had focused on peoples' increased levels of need in a negative sense, and had not followed guidance or strategies that had been suggested to support the person. They explained that they felt that this was to enable the provider to gather evidence to move the person to another home when their needs increased. However, when these concerns were raised with the registered manager they provided some context and explained that a conscious decision had been made to ensure that when assessing people when they first moved into the home, and through on-going assessments, that realistic expectations were held to ensure that the home was the correct placement for the person and that the facilities and staffing levels were able to meet peoples' needs.

People were able to voice their opinions and share their concerns within the relatives' and residents' meetings. The provider had a complaints policy and complaints that had been received had been dealt with according to the providers' policy and procedures. The registered manager encouraged feedback from

people, relatives and staff, there were regular questionnaires sent to obtain feedback and the providers' policy advised people of external organisations they could contact if they were unhappy about peoples' care. People and most relatives told us that they did not feel the need to complain but would be happy to discuss anything with the registered manager or members of staff. A relative told us, "A family member comes in most days and we would know straight away if anything wasn't right here but that's not the case".

Requires Improvement

Is the service well-led?

Our findings

People, relatives, staff and visiting healthcare professionals were complimentary about the leadership and management of the home and told us that the management team were supportive. Comments from staff included, "The manager is very approachable", "I think things have really improved since the manager came. Everyone works well as a team" and "I've worked in a lot of care homes and nursing homes and this is by far the best. It's a very warm and friendly place and the management have a lot to do with that". This positive feedback was also shared by people and relatives. When asked about the leadership and management of the home, a relative told us, "They do a very good job, I admire them". However, despite these positive comments, we found an area of practice that was in need of improvement.

The registered manager and staff ensured that records such as peoples' individual care plans, daily records and communication amongst the staff team, were maintained to demonstrate staffs' practice. A quality management system was in place that ensured that regular audits of the service, which included quality of life audits, were conducted by the registered manager and other external senior managers and were monitored by the providers' quality team. These monitored all aspects of life at the home, to ensure that people were receiving the type of care and support they had a right to expect. They also identified areas that needed to improve to ensure that the service that was provided continually met peoples' needs. Action plans as a result of the audits were implemented and monitored to ensure that any improvements that needed to be made were completed appropriately and in a timely manner. However, shortfalls in aspects of the provision of care had not always been recognised or measures taken to ensure improvements. For example, quality audits and associated actions had failed to recognise and address that there was a lack of person-centred and meaningful occupation for people, that staff did not have adequate opportunities to spend time with people and engage in meaningful conversations with them, that temporary staff lacked awareness of peoples' needs, abilities and conditions and did not take time to read peoples' care records to inform their practice. Furthermore, there was a lack of involvement from people and their relatives in the on-going review of peoples' care and in the explanation of the actions that were being taken in relation to peoples' care. This is an area of practice that is in need of improvement.

Forest View is one of a group of services owned by a National provider, Shaw Healthcare Limited. It is a purpose built building with accommodation provided over two floors which are divided into smaller units of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. The home also contains a day service facility where people can attend if they wish, however this did not form part of our inspection. The management team consisted of a registered manager, a deputy manager and team leaders as well as an area manager who regularly visited the home. There was a friendly, relaxed and welcoming atmosphere and people and relatives told us that people were content living at the home. The provider had a set of values which included kindness, wellness and happiness and it was evident that staff worked hard to implement these in practice. The provider valued staffs' contribution to the service and in 2008 had introduced the National STAR Awards which recognised staff who demonstrated excellence. The registered manager explained that she wanted to celebrate staffs' success and commitment to improve and had plans to hold a celebratory afternoon for staff that had either completed courses they had been working towards, or who had gained a STAR award.

The registered manager maintained links with external professionals to ensure that they continually improved the service and learned from other sources of expertise. These included the local authority, Parkinson's' nurses, Consultants, Dementia Crisis team, Dementia In-Reach team and the Living Well With Dementia team. These teams provide advice, training and information for care homes that provide care to people living with dementia. The registered manager attended regular meetings with other registered managers' within the area to share best practice. The registered manager demonstrated their awareness of the implementation of the Duty of Candour CQC regulation. Records showed that they had informed peoples' relatives if peoples' health needs or condition had changed. This was confirmed by relatives who told us that they were kept up-to-date when changes occurred. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. People and relatives were able to share their views and opinions about the home and the care people received. Regular residents' and relatives' meetings took place and annual surveys sent to enable the registered manager to receive peoples' feedback. Feedback from people had been listened to and acted upon. Most feedback related to items of peoples' clothing going missing. The registered manager explained that in response they had ensured that this task was delegated to particular staff so that there was less chance of peoples' clothing being put away in other peoples' rooms. Staff were involved and kept informed of any changes in the running of the home, regular staff meetings took place to enable staff to share their views and ideas. The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

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 Regulation 9 (1) (a) (b) (c) (3) (b) (c) (d) (e) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not always ensured that care and treatment provided to service users met their needs, was appropriate or reflected their preferences. Neither had the registered person always involved relevant people in services users' care.