BRIJ Care Limited

Forest Brow Care Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Forest Brow is a residential care home providing accommodation and personal care to up to 32 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 29 people using the service. The care home accommodates people in one adapted building on three floors.

People's experience of using this service and what we found.
People told us "I feel very safe. I'm not threatened in any way" and "I'm content. I'm fed and I'm independent. I don't get bossed about here." We received mixed feedback from relatives including, "We are very pleased with the care shown to [relative]" and "[Relative] is well cared for, but it is not the same place as before" and "Over the last year, due to the changes at the care home, we are not as confident as we were that we always have full insight into our [relative's] care."

On our inspection we found systems to oversee the quality and safety of the service were not effective throughout all levels of management. The provider did not maintain effective oversight of the service to support the registered manager to meet their responsibilities around providing good quality care.

Systems to identify and mitigate risk were not effective. Medicines were not managed safely. Risks related to the premises were not always safely managed, this included risks related to fire safety. Staff recruitment checks were completed for permanent staff however they were not always completed for agency staff. Further work was needed to ensure good infection control processes were being followed. Lessons were not always learnt when incidents occurred to reduce the risk of re-occurrence.

Systems and processes to safeguard people from the risk of abuse were not effective. The provider did not always report allegations of abuse in line with safeguarding requirements. This resulted in an increased risk of harm to people.

We found the principles of the Mental Capacity Act 2005 (MCA) were not always followed, for example in relation to the use of bed rails. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always receive training or training updates in line with their role. There were significant numbers of staff who required or were overdue updates in key areas relevant to their role, such as medicines; mental capacity; moving and handling; fire; safeguarding adults; first aid, infection control, deprivation of liberty safeguard (DoLS), food hygiene; dementia; end of life care and health and safety.

Some areas of the environment needed updating to ensure it met the needs of people. The home environment did not reflect dementia friendly best practice to best meet people's needs.

People's assessments and care plans were not always accurate or complete. People's care was not always personalised. Further work was required to reduce the risk of people experiencing social isolation through personalised activities.

Staffing was heavily reliant on agency staff and feedback from relatives included, "There is not enough, lots of agency" and "Staff are young and inexperienced from what I see". Feedback regarding permanent staff included, "We find the current permanent care team to be very kind and considerate to the residents" and "Day-to-day staff are lovely".

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

Rating at last inspection and update
The last rating for this service was Good (published 3 October 2019)

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding.

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

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

We have identified breaches in relation to dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, staff training, fit and proper persons employed and failure to submit appropriate statutory notifications to CQC.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Forest Brow Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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

Inspection team
This inspection was undertaken by 2 inspectors, an inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We visited the site on 17 October 2022 and 1 November 2022. We reviewed the home environment, made observations of mealtimes, medicines administration and staff interactions with people.

We spoke with the registered manager and 6 members of staff, including the deputy manager, maintenance staff and care staff. We spoke with 6 people using the service and received feedback from 13 people's relatives.

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 4 people's care plans, a number of medicines records and other care records. We reviewed policies and procedures, training records, audits and other records in relation to the running of the service.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely

- People did not always receive their medicines as prescribed; medicines were not always managed safely and records were not accurately maintained, this placed people at risk of harm.
- One person did not have a pain patch applied as prescribed for a period of 7 days on 2 separate occasions, which meant they may have experienced avoidable pain during this period.
- We found medicines, which had run out, had been signed as being given that day. On review, we identified that the wrong formula of the same medicine had been given without seeking appropriate professional advice. There were gaps within the medicines administration records (EMAR), meaning people may not have received their medicines consistently.
- Systems to ensure time specific medicines were given appropriately, such as medicines for Parkinson's disease, were not suitably robust. We observed a time specific medication being administered at 9.43am, this was due at 7am. Medicines that had been prescribed for night-time administration were consistently being given at 4pm, this type of medicine can make you sleepy. The people whose records we looked at that are prescribed these medicines had a history of falls, by not following the prescribed instructions this had increased the risk of harm to people.
- The provider did not ensure there were protocols in place for 'as required' (PRN) medicines and variable doses, including end of life medicines and medicines to support people with anxiety or agitation.
- Controlled drugs (CDs) are medicines that come under strict legal controls. We found CD stock balances were incorrect and did not reflect accurate totals within the building. The CD register contained errors, lacked essential information and CDs had not been accurately signed into the building. We found unaccounted CD stock in the CD cupboard. We found a record of CDs being in the building when they were not.
- Stocks of medication were not managed safely to ensure people had an adequate supply of their medicines. There was no evidence of regular auditing or stock checks of medicines.
- We found medicines in an unlocked office and the medicines fridge was unlocked. Fridge and room temperature monitoring records had significant gaps. There is a risk that medicines were stored outside of required temperatures, which could have affected the effectiveness of the medicines.

People's medicines were not being properly and safely managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, we asked the provider to send us a completed medicines audit. The registered manager completed and sent this, however there were still discrepancies recorded on this. Due to the level of concerns around medicines we raised a safeguarding concern to the local authority.

Assessing risk, safety monitoring and management

● The provider did not effectively manage risks in relation to fire. They had not acted to implement required actions identified in an external fire risk assessment completed in December 2021. For example, the doors of the fire evacuation route on the upper floors were not compliant with relevant regulations and posed a risk to people's safety – in that they did not automatically unlock and could impede timely and safe evacuation of residents in the event of a fire. Fire drills had been carried out, however the evidence showed staff were not effective in the evacuation of the building, there was no evidence the provider followed this up or had taken appropriate action. We were not assured staff were competent to safely manage an evacuation in the event of an emergency.

● On day 1 of our inspection a void space which was required to be locked was open and accessible. Staff were made aware. On day 2 of our inspection this was still unlocked. A smoke detector was found on day 1 that had a plastic blue bag covering it following maintenance work several weeks before the inspection, meaning it was ineffective in detecting smoke. This was removed immediately on staff being made aware. This had put people at increased risk of harm as it would not have detected a fire as effectively within that area.

● Regular maintenance checks of systems such as fire safety were not consistent and some of the records had missing entries. Checks may have taken place, but these were not documented. Faults that had been found did not always have the actions / follow up information documented on the paperwork. There were no emollient risk assessments in place for people who were prescribed topical creams. The use of these creams can pose an increased fire risk.

● Risks related to people's health, safety and wellbeing were not always appropriately assessed or managed. We received information from community nurses, who had attended the home to provide treatment for people. Nurses observed care had not been administered in line with care plans, and people's medical conditions had deteriorated.

● There were no care plans in place for people who expressed behaviours which may challenge staff or others related to agitation or anxiety. There was no evidence that incidents related to these behaviours were recorded to identify triggers or effective management strategies to keep the person, and others, safe.

● Where the provider had identified a risk, there were not always appropriate measures in place to manage that risk. For example, for a person, who had diabetes, there was guidance for staff on signs of high and low blood sugar, but no instruction of what a normal blood sugar range was and what to do if the levels go either side of these. Staff were responsible for checking the person's blood sugars. This increased the risk of the person's diabetes not being safely or effectively managed by staff, meaning they were at increased risk of harm.

Failure to manage risks to people's health and safety was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Equipment was maintained appropriately, and risks related to water safety were appropriately managed.

Preventing and controlling infection

● The service was not always clean. There was visible dust on handrails and shelves. Carpets looked worn and thin in some areas of the home. On day 1 we noticed a used mug that was on the floor in a hallway, this had clearly been there some time as there was mould growth present.

● Staff did not always follow good infection control practice. For example, a staff member was witnessed transferring medication from medicine pots to their un-gloved hand then putting tablets into a person's mouth. We observed staff wearing false nails and kitchen staff wearing nail varnish.

● We were not assured cleaning of the home was effective. Cleaning schedules were not consistently completed and records had missing entries. Infection control training for most staff was out of date. One

bath had a badly repaired scratch which increased the risk of infection as the bath could not be effectively cleaned.

You had failed to ensure that systems to prevent and control infection were implemented effectively. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was responding effectively to risks and signs of infection.

Systems and processes to safeguard people from the risk of abuse

- When concerns of allegations of abuse had been raised with the provider, they did not always robustly investigate and report allegations of abuse to appropriate safeguarding authorities. This put people at increased risk of harm.
- During the inspection we identified the provider had not taken appropriate action in response to a serious allegation of abuse in order to keep people safe or to appropriately investigate the allegation. Due to the levels of concern, we made a referral to the local safeguarding team and the police.
- We received concerns that night staff had been asked to get people dressed and out of bed early in the morning, regardless of their preferences. This was discussed with the registered manager on 1 November 2022 who confirmed that this had been the case and measures had been put in place to stop this practice, however the provider did not take appropriate actions to investigate and address the conduct of staff involved in implementing and enforcing this practice.

The provider failed to act on allegations of abuse immediately on becoming aware. This placed people at increased risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Pre-employment checks were not always carried out in line with the law for agency staff deployed in the service. We reviewed the records for 5 agency staff, we found that not all agency workers had the appropriate checks before being deployed in the service, this included obtaining references from previous employers, records of previous work and records of health conditions relevant to the applicant's capability to carry out the role.
- The home relied a lot on agency staff to cover shortfalls through the day and night. Feedback from staff and relatives supported the concerns around the shortage of permanent staff employed. For example, "There is not enough, lots of agency" and "Staff are young and inexperienced from what I see".

The failure to ensure appropriate staff recruitment processes were in place was a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Suitable recruitment processes were being followed for permanent staff employed by the service. Checks with previous employers and disclosure and barring service (DBS) were made. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes

● Visiting arrangements at the home were not in line with current guidance as there were restrictions in place to visiting. The service operated a booking service for visitors with a duration of up to 1-hour visits.

● Relatives told us the provider did not keep them up to date about current visiting arrangements at the home and that there was a lack of private spaces available when they visited their loved ones at the service.

● Feedback included "I haven't been able to go into [relatives] room for three years. I can't check their clothes and sometimes there not even wearing their own", and "I would like access to my [relative] more freely", "We are unable to visit our [relative] in their room privately."

● Further feedback included, "We would like more regular updates about the home's COVID-19 policy when it changes and to see it implemented consistently" and "Due to the home's COVID-19 policy, we have not been allowed to visit our [relatives] room for a long time".

We spoke to the provider regarding the visiting arrangements and recommended they address this. We recommended communication be sent to relatives clarifying the visiting policy.

Learning lessons when things go wrong

● We were not assured lessons were learnt effectively in response to incidents or accidents to reduce the risk of re-occurrence.

● The provider had a monthly analysis form in place for incidents, however the information documented was not always robustly recorded or completed in full and did not ensure that analysis and lessons to be learnt about how incidents occurred were acted on.

● When people had unwitnessed falls or sustained an injury there was no record that the local authority or safeguarding team were appropriately informed in line with their requirements. This was discussed with the registered manager who stated that this would be implemented immediately.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where people had a condition of the mind or brain which may affect their mental capacity to make specific decisions, the provider had not undertaken mental capacity assessments. There was no evidence people were provided with relevant information to support them to make specific decisions, such as the options, risks and benefits, or to show how the decision made was in their best interest, if they lacked the capacity to make it.
● People had restrictive measures in place without documenting their consent or demonstrating they lacked capacity to consent through a mental capacity assessment. The provider could not demonstrate restrictions in place were in people's best interest as there was no evidence of involvement of people, their relatives or those lawfully acting on their behalf to make those decisions. These restrictions included the use of door sensors, bed rails and floor sensor mats, which could limit the person's privacy and freedom of movement in the home.

Failure to obtain consent from the relevant person for care or treatment decisions was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
● The provider's training records showed not all staff had completed training or refresher training as required by the provider and which was relevant to their role. This included training in subjects such as

moving and handling; fire; safeguarding adults; first aid, infection control, deprivation of liberty safeguards (DoLS), food hygiene and health and safety. This meant there was a risk people were cared for by staff without the knowledge and skills to fulfil the requirements of their role.

● Staff were administering medicines without receiving refresher training. Some staff were administering medication without receiving training on the electronic medicines administration record system which is in use at the service. This increased the risk of medicines administration errors and risk of harm to people.

● Not all staff received training and refresher training in line with the people's needs and the provider's policy. Dementia training was identified in the provider's policy for all staff to have, and to be refreshed yearly. Some staff had not received this training since 2017 and some had not received this at all.

● Staff had not received training in end of life care or training around positive behaviour management in line with the needs of people using the service. There was no training around specific conditions, for example, diabetes or Parkinson's disease. The provider was unable to evidence staff competencies for moving and handling.

● Staff told us they did not have enough training. Feedback from staff included, "I didn't have any induction. I started at 8am by 9am I was working on the floor with the residents" and "I haven't received any training since I started here."

● People's relatives told us that staff were not always skilled in supporting their loved ones. Feedback from relatives included "One staff member does tend to "pat" our [relative] on the head and therefore I do feel some training could be given in this area".

The failure to ensure staff received appropriate training was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The home was reliant on agency staff however there were enough staff to meet the needs of people. Feedback from people included, "They could probably do with more, but it's all right" and "Sometimes they have agency staff, girls you haven't seen before to fill a gap".

● Other feedback from people included; "I feel very safe. I'm not threatened in any way" and "There's always someone on call; you're not on your own."

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

● The dining experience for people was very task focussed and not very relaxed. Staff were seen supporting several people at once which was not always person-centred, however, there were times we observed kind and compassionate interactions between staff and people.

● Information on food options was not available. There were no menus on the table and the board to display meal choices in the dining room was not completed. People did not appear to know in advance what the meal was going to be. However, it was clear that at some point they had been given a choice of what to have as people were provided with different meals.

● Drinks were offered but options for people were limited, we observed orange squash was available in one room and blackcurrant in another, or water. We observed staff did not offer people a choice of what to drink or where to sit for mealtimes. One person told us, "You sit in an allocated place. They tell you where to sit."

● Feedback from people about the meals was positive, for example, "It's fine. It's very good, I've got no criticisms" and "The food is very good. There was a choice today for a change. I always have fresh fruit."

Assessing people's needs and choices, delivering care in line with standards, guidance and the law

● There was evidence of people's needs assessments being carried out prior to admission. A relative told us, "Yes, it was done at the house before [relative] came here", however there was a lack of evidence within the records to demonstrate that support was delivered as assessed and in line with national guidance and standards.

● Best practice would be to utilise a range of nationally recognised tools to ensure people's needs were assessed robustly. For example, the use of the Malnutritional Universal Screening Tool (MUST) to monitor people's risk of malnutrition. There was evidence of people's weights being recorded however the records showed contradicting information. For example, a care plan stated that [person] is to be weighed weekly then further down the care plan it stated [person] to be weighed monthly. Therefore, we could not be assured that people's weight was monitored effectively to identify and address any concerns.

Staff working with other agencies to provide consistent, effective, timely care
● There was evidence of communications with GPs and District Nurse visits. A referral had been made to the falls team and there was evidence of the speech and language therapy team being involved with people who required them.
● Feedback from relatives when asked if staff contacted the doctor for their relative if they were feeling unwell included, "The district nurse came about [relative's] legs" and "We believe this is the case, if necessary, but we are not always updated at the time."

Adapting service, design, decoration to meet people's needs
● Aspects of the home's décor were not dementia friendly, in line with best practice guidance. Bedroom doors had small name plates but there was no personalisation to help orientate people who had dementia. Some name plates were blank and not completed.

We recommend the provider review and implement dementia friendly guidance in providing an appropriate home environment to best meet people's needs.

● There was enough space for people and the building was accessible for people with different mobility needs. There were clear pictorial signs on the lounge, dining room and toilet doors to help people navigate these areas.

Supporting people to live healthier lives, access healthcare services and support
● Some people's relatives felt they were not always informed about people's health needs straight away. A relative stated "We are not as confident as we were that we always have full insight into our [relative's] care" and "I don't really get any feedback on how mum is".
● People were supported to access most healthcare services as needed.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● Staff did not always respect people's privacy and treat them with dignity, resulting in people not always feeling they were respected or valued. For example, one member of staff told a person to stop moving their wheelchair in case they "upset the chair and smashed [their] head open". When the person complained that this was unfair, the staff member responded, "Life isn't fair, but we still have to put up with it." We raised this with the registered manager who addressed this with the member of staff involved.

● We observed one person with something caught in their mouth. The person put this into the staff member's gloved hand. The staff member said to the person, "Oh, lovely. Please don't touch me." Again, this was raised immediately with the registered manager.

● The dining experience for people was very task focused. People who needed more assistance were sat in one room whilst those needing less assistance were sat in another. This was done without asking people their preference. When people were finishing their meals, we observed staff speaking loudly about who was doing what and who was taking who to the toilet. This was not respectful of their privacy and demonstrated people were not always treated with dignity by staff.

● We observed staff discussing who they were going to assist, what they were going to do and in what order, over the heads of the seated people at the dining table. Staff stood beside people to assist them to eat with one staff member reaching over the table to assist a person, rather than promoting their dignity by sitting with them.

The failure to ensure people's privacy and treat them with dignity and respect was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider had not fully considered people's protected characteristics in relation to how their care and treatment was provided. A number of people were living with dementia. There was a lack of evidence to demonstrate how their needs, for example, in relation to either their environment or their care needs had been met. For example, there was nothing to orientate people to time and place, the décor was not dementia friendly and there was a lack of evidence that people were being supported to maintain as much independence as possible.

● Relatives we spoke to were generally positive about staff. One told us, "The care staff are lovely", others said, "We find the current permanent care team to be very kind and considerate to the residents", and "Day to day staff are lovely".

● We observed staff interactions with people, which were mixed. Some were positive, such as staff offering

people a choice of drink and complimenting them on their appearance. Other interactions were lacking kindness and respect, included giving people their food without any communication, ignoring them or being very task focused rather than on the person and their wellbeing. We saw one person spend time trying to get food from the empty part of their plate and having the food taken away as lunchtime had ended, rather than staff recognising they just needed a little support to finish their meal.

Supporting people to express their views and be involved in making decisions about their care

● People's choices were documented in their care plans but were not always consistently respected. People were not always given information, or information was not provided in a way people could understand to support them to be involved and make decisions about their care.

● Where people had expressed preferences or made decisions, these were not always respected. For example, where people had requested two-hourly night checks, we found there was no record these checks were being completed. We arrived at the home before the day-staff had arrived. We observed a person who stated they would like to get up after 8am, was in the lounge on our arrival over an hour before this time and was sleepy in a chair.

●Feedback from relatives included, "We have not been provided with an updated copy of our [relative's] care plan for over a year. We have previously asked for a copy and are waiting for an updated version".

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People had care plans in place, but they were not always up to date and reflective of their needs. For example, when we reviewed one person's care plan there were wound plans still showing as active from 2020 even though there were no current wound concerns for this person. Feedback from relatives included, "Some of the information within it [care plan] was repeated and not up to date. There was also some information that had been discussed that wasn't included, such as medication."

● Care plans did not always have adequate information for staff to provide consistent, person-centred care. One person was prescribed medicine to take when agitated or very anxious. However, the care plan did not include positive behaviour strategies, triggers and diversion techniques. This meant that staff members may not have had the appropriate knowledge required to respond to the person's needs.

● Some care plans had areas that were detailed and reflected the care that a person required. Life histories for people were documented in care plans. Some were very detailed and had lots of information about the persons history, likes, dislikes and hobbies. Staff were generally knowledgeable about people's likes and dislikes.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People had communication plans in place and staff understood people's communication needs. For example, one staff member told us how they looked at facial expressions, gestures or changes in a person's mood to assess whether they may be trying to communicate they were in pain.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Throughout the inspection we observed a lack of meaningful or stimulating interaction, and people were spending time with no option of an activity. Although we observed some staff engaging people in games, activities were not personalised to meet the needs of all people with dementia or in line with their personal history. There were limited opportunities for reminiscing, occupation or activities to support people in feeling valued.

● Feedback from people included "I don't want to join in at the moment, but I would like to be asked about what I'd like to do," "There's nothing to do, there was nothing to do before the activities lady left," and

"There's no stimulation, for your mind or your body. You just sit around all day."
● Feedback from relatives included "The care home's ability to be responsive to residents' individual needs in terms of mental stimulation and physical activities is very limited" and "We would appreciate improved opportunities for individualised activities sessions for our [relative] to support their mental well-being."
● People were able to freely access the outdoor space.

Improving care quality in response to complaints or concerns
● There was a complaints log in place which evidenced responses made.
● Not all relatives knew who they would complain to if they needed, for example one relative stated "We don't know who owns the home. We have not received any information regarding who the point of contact is." and "We wrote to the registered manager regarding [relative's] decline but the registered manager never answered, so we phoned but the registered manager would not talk to us."

End of life care and support
● There was no evidence of staff receiving end of life care training.
● End of life care plans that we reviewed were detailed and documented people's choices and wishes on how they wanted to be cared for.
● People's friends and relatives had been consulted about the end of life needs of their loved ones.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At this inspection, we found breaches in multiple regulations. The provider's governance system was ineffective in identifying where fundamental standards were not being met or driving improvements where required.
- Audit processes were not robust and did not provide an effective system to oversee the quality and safety of the service. Some audits were not completed, whilst it was not clear from completed audits how issues and actions were followed up to promote improvement. For example, the provider had not identified gaps in assessing people's capacity and ensuring care was least restrictive of people's freedoms.
- Care records lacked detail and were not always kept up to date. This meant that it was not always clear whether care had been delivered and whether it was in line with people's needs.
- Oversight of quality and safety of the service was not robust. There was no oversight of delegated tasks and audits by the provider or registered manager to ensure these were completed appropriately and any actions taken, where required.

Failure to ensure systems were in place to monitor and mitigate risks to people and maintain accurate and complete records is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The registered manager did not fully understand their legal responsibilities. Statutory notifications were not always sent to CQC when required. This included allegations of abuse.

Failure to notify is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Care staff told us that members of the management team did not work effectively together to promote a consistent, clear and positive approach.
- Staff told us they did not feel supported in their role by management, which led to a culture where they felt unable to raise issues or make suggestions. One staff member we spoke to when asked if they would be happy for their family member to be cared for at Forest Brow told us, "No, because of how staff are treated by the people above them." Another said "I'm not sure to be honest. Staff levels are a concern."
- The registered manager was engaging throughout the inspection process. They were open and

transparent where issues were identified.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities to be open and honest, and the requirements of duty of candour with people or their loved ones where something went wrong.

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

● There was mixed feedback about communication and engagement with relatives. Feedback included, "We don't always find the management team to be as accessible and approachable" and "The management lacks approachability."

● There were no meetings with people or their relatives to gain their views and feedback. Relatives told us, "We don't have relatives and resident's meetings, we used to but haven't for a long time" and "We used to receive a monthly newsletter but the last one was about three years ago".

● There was evidence of staff meetings taking place however when speaking with staff they told us they did not feel able to make suggestions or raise issues.

Working in partnership with others

● We received feedback from professionals who felt the management team did not foster positive relationships with them which had impacted on people's care.

Continuous learning and improving care

● Learning and improving had been limited, however the provider and registered manager had recently put an action plan of improvements in place. At the time of our inspection this was still being developed.

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 18 Registration Regulations 2009 Notifications of other incidents Failure to notify is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to ensure people's privacy and that they were treated with dignity and respect was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to obtain consent from the relevant person for care or treatment decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Incorrect recruitment processes. Recruitment checks were not always carried out in line with the law. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff received appropriate training was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 The failure to safely manage medicines, mitigate risks to people's health and safety, assessing the risk of and preventing, detecting and controlling the spread of infections. was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

A warning notice was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to action allegations of abuse immediately on becoming aware is a breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

A warning notice was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure systems were in place to monitor and mitigate risks to people, and maintain accurate and complete records is a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

A warning notice was issued