Shaw Healthcare Limited

Deerswood Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 26 and 28 July. 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.

Deerswood Lodge is a residential care home providing accommodation and personal care for up to 90 older people, some of whom have physical disabilities or are living with conditions such as diabetes and dementia and who may require support with their personal care needs. On the day of the inspection there were 82 people living at the home.

Deerswood Lodge is situated in Crawley, 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 of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. There are well-maintained 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, two unit managers and team leaders.

We previously carried out an unannounced comprehensive inspection on 8 June 2016. A breach of a legal requirement was found in relation to safe care and treatment, as risks to each person's individual needs were not always identified or minimised and risk assessments and care plans were not always sufficient. Due to this, staff were not provided with sufficient guidance to inform their role and ensure the person's safety. It was also identified that the recording of conditions associated with peoples' Deprivation of Liberty Safeguards (DoLS) authorisations and staffs' awareness of these was an area in need of improvement. The home was rated as 'Requires Improvement'.

At this inspection it was evident that improvements had been made within these areas. The registered manager and staff had a good awareness of the Mental Capacity Act 2005 (MCA) and had assessed peoples' capacity and made the necessary applications to the local authority when people needed to be deprived of their liberty. There was an awareness of the conditions associated to authorisations of DoLS and these were clearly documented in peoples' care plans to inform staff and guide their practice. Risk assessments had been completed that identified the hazards and the measures that had been put into place so that staff were provided with guidance to inform their practice and ensure peoples' safety.

The inspection was prompted in part, by a notification of a death of a person who lived at the home. The incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the death and the incident prior to it,

indicated potential concerns about the management of risk in relation to falls. This inspection examined those risks.

There was mixed feedback with regard to the sufficiency, deployment and abilities of staff. People told us and records confirmed that people sometimes had to wait unacceptable amounts of time to received support. One person told us, "It's not nice when you have to wait about ten or fifteen minutes to use the commode". The registered manager was in the process of recruiting staff, however, in the interim period had ensured that agency care staff were available to meet peoples' needs. People told us and our observations confirmed that some agency staff lacked the knowledge, abilities or understanding of peoples' needs and sometimes failed to engage or interact with people. A comment from one person echoed this, they told us, "Sometimes the agency staff aren't so good but the main ones know me and I get what I need". The skills, sufficiency, supervision and deployment of some staff is an area of concern.

There were quality assurance processes in place to enable the registered manager to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. However, we found several examples of where this had failed to identify incomplete records. Records were not always completed in their entirety and therefore it was unclear if people had not received the level of care required or if staff had failed to document their actions in records.
Not all people had access to the varied range of activities that were offered. There was an apparent difference in the provision of activities or the stimulation and interaction provided to people, particularly for those who were living with dementia and who were less able to engage in activities. We have made a recommendation about the provision of meaningful activities for all people.

People were protected from harm and abuse. There were appropriate, skilled and experienced, permanent staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. Peoples' freedom was not unnecessarily restricted and they were able to take risks in accordance with risk assessments that had been devised and implemented. When asked why a person felt safe, they told us, "I don't worry about burglars or getting mugged here".

People received their medicines on time and according to their preferences, from staff with the necessary training and who had their competence assessed. There were safe systems in place for the management, storage, administration and disposal of medicines.

People were asked for their consent before being supported. People and their relatives, if appropriate, were fully involved in the planning, review and delivery of care and were able to make their wishes and preferences known. Care plans documented peoples' needs and wishes in relation to their social, emotional and health needs and these were reviewed regularly.

Staff worked in accordance with peoples' wishes and people were treated with respect and dignity and were involved in their care as much as they were able. It was apparent that permanent staff knew peoples' needs and preferences well. Positive relationships had developed amongst people living at the home as well as with staff and people were encouraged to maintain contact with their family and friends.

People's health needs were assessed and met and they had access to medicines and healthcare professionals when required. One person told us, "The doctor comes in on Wednesdays so you can ask to be seen if you need to".

People had a positive dining experience and told us that they were happy with the quantity, quality and choice of food. One person told us, "The foods really good and there's a good selection". Another person

told us, "I'm a hungry person and they make sure I get plenty".

The registered manager welcomed feedback and used this to drive improvements and change. Compliments and concerns were shared with staff to promote learning and reflection. People, relatives, staff and healthcare professionals were complimentary about the leadership and management of the home. One person told us, "The manager is approachable and happy to listen to you". People told us that they were happy at the home. One person told us "I think it's beautiful and couldn't be better".

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe.

People told us that they sometimes had to wait for support from staff and that this had an impact on the care they received. Records confirmed that sometimes staff were unable to respond to peoples' needs in a timely manner.

Risks to peoples' safety had been assessed. 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.

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 for their consent before being supported. Appropriate assessments had been made to determine peoples' capacity and appropriate referrals were made to the local authority if people needed to be deprived of their liberty to ensure their safety and well-being.

People were happy with the food provided and were able to choose what they had to eat and drink. People 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 health care 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.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People had access to a range of activities; however there was a lack of engagement and stimulation for people who were less able to take part in activities.

Care was personalised and tailored to peoples' individual needs and preferences.

People and their relatives were made aware of their right to complain. The 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 were in place to monitor the care people received. However, they had failed to identify that records to document the care that people received were not always completed. This meant that it was unclear if people had not received appropriate care or if staff had failed to record their actions.

People, relatives, staff and healthcare professionals were positive about the management and culture of the home.

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

Deerswood Lodge

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 26 July 2017 and was unannounced. The inspection team consisted of three 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 28 July 2017 and was announced. The inspection was prompted in part, by a notification of the death of a person living at the home. The incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the death and the incident prior to it, indicated potential concerns about the management of risk in relation to falls. This inspection examined those risks.

Prior to this inspection the provider had completed a Provider Information Return (PIR), 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. Other information that we looked at prior to this inspection included previous inspection reports, feedback that we had received about the home and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with twelve people, seven relatives, twelve members of staff, the registered manager and a visiting healthcare professional. Prior to the inspection we had communicated with a professional from the local authority to gain their feedback. Following the inspection we communicated with 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 twenty people, medicine administration records (MAR), twenty staff records, 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' own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

The home was last inspected in June 2016, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 8 June 2016 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to each person's individual needs were not always identified or minimised. One person, chose to pursue a particular lifestyle choice, although this was respected by staff, there was not sufficient assessment of the possible risks and hazards that this could create. Due to this, staff were not provided with sufficient guidance to inform their role and ensure the person's safety. At this inspection it was evident that improvements had been made. Risk assessments had been completed that identified the hazards and measures had been put in place, or offered to the person, to maintain their safety. It was also evident that the registered manager had learned from a serious health and safety incident that had occurred at another service and had implemented the necessary precautions to avoid an incident such as that from occurring. Therefore the provider was no longer in breach of the Regulation.

There was mixed feedback with regard to the staffing levels. Some people, relatives and staff felt that there was sufficient staff to meet their needs, whereas others told us that additional staff were sometimes needed. Comments from relatives included, "Safety very good they look after them well, there is always someone about when we come", "Staff sit and talk with them, and we have a laugh and joke, that's how it's got to be - a pleasant atmosphere", "When they get really busy they are marvellous at coping". Other comments from relatives stated that they felt that the staffing levels were insufficient. Comments included, "If you have someone really bad you've got staff dealing with them and everyone has to wait", "I think sometimes at the weekend they could do with another person" and "I have told them many times they need a floater, they only have two in here, they have two people who are in bed, some days it is quite quiet, some days it's horrendous. When they have to reposition someone in bed, there is nobody in here (lounge)". One member of staff, who was not directly involved in peoples' care, told us that they sometimes had to change roles and stop what they had planned to do in order to meet peoples' care needs when there were not enough staff.

Each single unit had two members of staff allocated to it. The units were open plan and led on from one another so staff could call upon staff from the other unit if further assistance was required. There were mixed observations regarding the sufficiency, deployment and abilities and supervision of staff to meet peoples' needs. Observations showed that staff were hardworking and busy, however during quieter periods of the day they took time to sit with people and interact with them. The registered manager was in the process of recruiting more permanent staff, however, in the interim period had ensured that shifts were covered by agency staff. Some of the units had agency staff working alongside existing members of staff. It was evident that this had some impact on staffs' ability to meet peoples' needs. Some agency staff had worked at the home before, however, some had not and we observed that they did not always know peoples' needs. At times, agency staff were not interacting with people and instead were carrying out tasks or sitting down away from people. It was not apparent that agency staff were supervised or directed as to the requirements of their role. The practices and interaction provided by agency staff was supported by one person's comment, they told us, "Sometimes the agency workers aren't so good but the main ones know me and I get what I need". There were missed opportunities for interaction and engagement with people, as some people were sitting on their own without staff support.

Records showed and people confirmed that staffing levels sometimes had an impact on peoples' care. Each room had a call bell system that people, who were able, could use to summon assistance from staff. Throughout the inspection call bells were continuously ringing and records for the response times to call bells over the previous month, showed that on most occasions these had been answered in a timely manner. However, one record showed that one person had had to wait for 20 minutes before staff responded to their needs. This was raised with the registered manager who was unable to recall or provide an explanation for this specific incident. Although there were no documented audits of the call bell response times, we were informed, subsequent to the inspection, that these were monitored on a daily basis and that the registered manager was informed if there were any unacceptable delays to enable them to investigate times when people had waited for staff support. Peoples' comments confirmed that staffing levels had an impact on their care. One person told us, "It's not nice when you have to wait about ten or fifteen minutes to use the commode". Another person told us, "You just have to be patient, it's not their fault". A relative told us, "They have said during the day there have been staff shortages and they've had to wait for them to come". A healthcare professional told us that they had often witnessed occasions when people had had to wait for staff support if they had needed assistance with their personal care if they were not independent in managing their continence needs.

When these findings and comments were raised with the registered manager, they showed us a statement that had been issued by the provider with regard to staffing levels. It stated that staffing levels were based on peoples' level of need. Prior to admission each person was assessed to identify their needs; this was then used to inform the funding for staffing levels by the local authority or the clinical commissioning group. If peoples' needs changed after this time then a 48 hour monitoring chart was completed that demonstrated the amount of support the person required. This was then used to obtain additional funding to increase the staffing levels.

Although the provider had taken into account peoples' needs, it was apparent that the use of agency staff had at times, had an impact on the level of care people received. The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled, experienced and supervised staff deployed to meet peoples' needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had notified CQC about a death that had occurred in the home. An incident that had occurred prior to the death indicated potential concerns about the management of risk in relation to falls. The incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. During this inspection we looked at individualised risk assessments that identified risks that were specific to peoples' needs and health conditions. Assessments of peoples' needs had been undertaken prior to their admission to the home. Following admission risk assessments and associated care plans had been devised, which identified the hazards and risks to peoples' safety as well as measures to be taken to minimise risks.

Accidents and incidents that had occurred were recorded and analysed to identify the cause of the accident and determine if any further action was needed to minimise the risk of it occurring again, such as the updating of risk assessments or the referral to relevant external healthcare professionals. The registered manager had learned from a serious incident and had ensured that senior staff received training in recognising deteriorating conditions. They had also introduced measures to ensure that people were sufficiently monitored if they had been involved in an accident, such as a fall. A 72 hour post-fall monitoring form had been implemented which staff were required to complete enabling them to monitor any changes in peoples' health conditions. However, records for one person, who had had a fall during the early evening, the day before the inspection, showed that staff had documented their observations overnight for a period

of 13 hours following the fall; however, there were no other documented observations after this time. Observations showed the person, the day after their fall and within the 72 hour period, to be sleeping for most of the day, resulting in them not eating their lunch until 5:30pm. When this was raised with staff they explained that the person usually slept during the day. Although the person was in the communal lounge, where staff were present, records did not show that staff had monitored the person for any signs or symptoms of injury the day after their fall. When staff were asked why the 72 hour post-fall observation record had not been completed they told us this was because there were agency staff working that day and they had not completed the records. However, when this was raised with the registered manager, subsequent to the inspection, it became apparent that other records, which monitored the person's condition, were not viewed and staff did not make it clear that there were other mechanisms in place to monitor people. The registered manager explained that there had been two 72 hour post-fall forms and that one of these was fully completed by staff and the other form, which contained the gaps in recording, had been completed in error. Other records were also in place that documented how staff had monitored and responded to the person's condition, this included a 30 minute observation record and the daily records. Documentation to show that the person had been visited by their GP was also in place.

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. In addition to this, their suitability to work in the health and social care sector was 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. Where people received support from agency staff, the registered manager had requested a profile from the agency which included information on their DBS and a record of their training. Profiles had been provided for some agency staff working at the home, however, we identified one agency member of staff where the provider had not been provided with information on their DBS and training. This posed a potential risk as the registered manager had not ensured that the agency member of staff had received appropriate training to safely meet peoples' needs and that they had an up-to-date DBS check. The registered manager contacted the agency to obtain this information and advised that in future, full profiles would be requested for all agency staff to ensure the suitability of agency staff to safely meet peoples' needs.

People, their relatives and healthcare professionals told us that the home was a safe place to live. Observations showed that people felt safe and free from harm at the home. People were smiling and looked relaxed in the company of staff. People asked for help and support from staff who were only to happy to help. When asked why a person felt safe, they told us, "I don't worry about burglars or getting mugged here".

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. Incident records and body map charts recorded injuries that people had sustained so that these could be monitored to ensure peoples' safety. The registered manager had a good understanding of safeguarding and was responsive to concerns with regard to peoples' welfare. They had made referrals to the local authority to safeguard people from harm and abuse, and in addition, had also cooperated with the local authority when they were looking into safeguarding concerns to assure peoples' safety. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to people and 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.

Peoples' freedom was not unlawfully restricted and they were able to take risks. Observations showed some people independently mobilising around the home and gardens as well as accessing the local community. An innovative approach to promoting independence whilst ensuring peoples' safety took the form of a 'Mind

Me' locator. This device would be taken out by the person accessing the community, a time that the person expected to be home was discussed and if the person did not return home by that time staff could identify and locate where the person was and contact them to ensure their safety and ask for a new time to expect the person home. A member of staff told us, "I support people to live as independently as possible and assess any associated risks such as mobilisation, potential falls and eating and drinking". Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure that the building and equipment were maintained to a good standard. Regular checks in relation to fire safety had been undertaken and peoples' ability to evacuate the building in the event of a fire had been considered, as each person had an individual personal emergency evacuation plan. A business continuity plan informed staff of what action needed to be taken in the event of an emergency.

People were assisted to take their medicines by staff that had received the appropriate training and who had their competence regularly assessed. An electronic recording system for the management of medicines was used. 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 assisted them to administer medicines safely as it informed them of what medicines were due as well as the stock levels of medicines. The registered manager used the system to monitor and audit the administration of medicines to identify if any errors had occurred. Observations showed peoples' consent was gained and they were supported to take their medicine in their preferred way. People, who were able, told us that they received their medicines safely and on time. A relative told us, "They have access to pain relief, they ask for it". Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. Some people were supported to have their medicine covertly. People who may not be able to make decisions about their care and treatment may need to be given their medicines without them knowing, for example, hidden in their food or drink. Records for one person showed that the registered manager had assessed the person's capacity to make a decision with regard to their medication and had ensured that a best interests decision with the persons' GP, had taken place. People, who were able, were encouraged to continue to self-administer medicines and relevant policies and risk assessments were in place to ensure their safety.

Good

Is the service effective?

Our findings

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).

At the previous inspection on 8 June 2016, it was identified that the recording of conditions associated with peoples' DoLS authorisations and staffs' awareness of these, were areas of practice in need of improvement. At this inspection 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 recorded and met. The registered manager had a good understanding of the MCA and had ensured that the necessary assessments of peoples' capacity had been undertaken. When required, appropriate referrals to the local authority had been made to deprive people of their liberty. The registered manager had ensured that improvements were made in relation to ensuring staffs' awareness of when authorisations had been granted as they had ensured that these were stored in peoples' care plans for staff to access so that they were aware of any conditions that were associated with these.

People, relatives and healthcare professionals told us that they felt that staff had appropriate and relevant skills to meet peoples' needs. Comments from relatives included, "Yes I do, I can only go with my experience, when you get new people in they have to show them" and "What I can see they seem to be, the ladies seem to be extremely caring". A visiting healthcare professional told us, "The staff know what they are doing, for example, just now a person started to choke and the member of staff left the drugs trolley to attend to the person but asked someone to watch it until they had dealt with the situation and returned. I observe good practice and the staff do ask about personal information about people, they seem genuinely interested".

The registered manager had a commitment to learning and development. Staff that were new to the home were supported to undertake an induction which consisted of familiarising themselves with the provider's policies and procedures, orientation of the home, as well as 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.

Staff had completed training which the registered manager considered essential to their roles as well as completing training that was specific to the needs of the people they were supporting, such as diabetes and supporting people living with dementia. Some staff held Diplomas in health and social care, whereas others were working towards them. There were also links with external organisations to provide additional learning and development for staff, such as the local hospice and external healthcare professionals. Staff told us that they received sufficient training to enable them to provide care to people in a competent and consistent

way. One member of staff told us, "I feel confident looking after a person who has diabetes and I know what to look for if the person had high or low blood sugar levels". Another member of staff told us, "There are good opportunities for training".

People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss their needs and any concerns they had. They 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 and appraisals helpful and supportive, however, explained that they could also approach the registered manager at any time if they had any questions or concerns.

Peoples' communication needs were assessed and met. Observations of staffs' interactions with people showed them adapting their communication style to meet peoples' needs and assisting people to use technology to aid communication. For example, when supporting a person who had a hearing impairment staff assisted the person to change the batteries in their hearing aid so that they could hear others speaking to them. The person told us, "I wear two hearing aids, always got them in, they keep an eye on the batteries". There was effective communication between staff. Regular handover meetings and team meetings, as well as detailed care plans, ensured that staff were provided with up-to-date information to enable them to carry out their roles.

Peoples' health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, opticians, dentists, dieticians, speech and language therapists (SALT) and district nurses. Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support and people confirmed this. One person told us, "I have my feet checked I think it's about every three or four weeks" and "The doctor comes in on Wednesdays so you can ask to be seen if you need to". A relative told us, "My relative knocked their legs and lost weight after a mini bug and they were on it and got the GP out". Observations showed staff adopting an innovative approach to monitor people who had complex long-term health conditions. This was a joint initiative between the provider and the local GP surgery, the results of which were monitored by community nursing teams. A handheld device was used to monitor if people were showing signs of atrial fibrillation, if signs were apparent, intervention could then be offered before any conditions escalated so as to reduce the risk of strokes or further disease.

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's 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 people were weighed so that they were monitored more closely. In addition, peoples' food intake had been recorded to monitor what people were eating. Referrals to health professionals had also been made for people who were at risk of malnutrition, these included

referrals to the GP, dietician and SALT.

People had a positive dining experience and told us that they enjoyed the food and had a choice of menu each day. People ate their meals in the dining room, or in their own rooms, dependent on their preferences and care needs. The dining rooms created a pleasant environment for people, tables were laid with tablecloths, placemats and condiments and people could choose what they had to eat and drink. People told us that they enjoyed the food. Comments from people included, "I have toast and a poached egg for my breakfast but I could have a full English if I wanted", "The food is really good and there is a good selection" and "I'm a hungry person and they make sure I get plenty". A relative told us, "I sometimes stay for lunch and I think it's quite a balanced menu. As well as your jam roly-polys, there is fruit and veg too".

Good

Is the service caring?

Our findings

There was a friendly and relaxed atmosphere and people were cared for by staff that were kind and caring. People and relatives were complementary about the caring approach of staff and told us that people were well cared for. Comments from people included, "They are good, caring people and help you as much as they can" and "They treat me well here, so kind you couldn't find a better place with staff like these". A relative told us, "Just the way they talk to them you can see they care for them, they're not just doing a job, they have a rapport with them". A visiting healthcare professional told us, "They are a cheerful staff group and you never see anyone tutting at anyone, no negative approaches". Another healthcare professional told us, "They are very caring and excellent staff. I think the carers, team leaders and home manager are very good.

Observations of staffs' interactions showed them to be kind and caring, they took time to explain their actions, offer reassurance and ensure people were comfortable and content. One person was showing signs of apparent anxiety and distress. Staff took time to interact with the person, talking about the person's family and what they would like to do. It was evident that this had a positive impact on the person as they were seen smiling and holding the member of staff's hand. This was further confirmed by a comment made by a relative, who told us, "They do get upset when I go and the staff take them back with them and talk with them". Observations showed a member of staff speaking to a person; they were overheard saying, "Are you alright? You've got bare arms; can I get you a cardigan or a jacket"? The person was happy for them to do this and it was promptly followed through with gentleness in assisting to put the cardigan on and a cheerful exchange about lunch being on its way. People were treated with respect and were able to independently choose how they spent their time. One person told us, "That works both ways showing respect. We speak to each other in a proper manner. The staff are very polite".

Peoples' independence was promoted and encouraged. Observations showed some people independently accessing the community or spending time in the garden. Other people, who were less able to access the community and outdoor space independently, were observed walking around the home using their mobility aids and choosing where and how they spent their time. Comments from people included, "Whilst we've had this nice weather I could go outside and sit in the garden and have my meals there in the shade" and "I just go and walk around as I like". People were encouraged to maintain relationships with their family and friends, some enjoying lunches together as well as receiving visits throughout the day. People appeared to enjoy interacting with staff and it was apparent that caring relationships had been developed.

Peoples' privacy was respected. Information held about people was kept confidential as records were stored in locked offices to ensure confidentiality was maintained. Staff showed a good understanding of the importance of privacy and dignity and people confirmed that these were promoted and maintained. One person told us, "Your room is your private space. They don't go in your room without asking first". Observations further confirmed that peoples' privacy was respected, when discussing information of a personal nature, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. Meetings to discuss peoples' changing needs took place in private offices to ensure others didn't hear the content of the conversations.

Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences and to ensure people were treated equally and fairly. Needs in relation to peoples' disability, gender, faith and sexuality were recorded in care plans. People told us how well their individual needs were met. 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. One person told us, "I've got lots of my own clobber in here, look at it all". Observations showed one person, who was living with dementia, had been supported by staff to style their hair and have make-up applied as the persons' family had informed staff that this is how the person would have preferred to have presented themselves before they moved into the home.

People and relatives told us that people were involved in decisions that affected their care and our observations confirmed this. Records showed that people and their relatives had been asked peoples' 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 surveys were sent to people and their relatives to gain their feedback. Regular residents' and relatives' meetings took place, however, these were not well attended as people and relatives confirmed that they felt fully involved in the delivery of care and could approach staff if they had any questions or queries relating to it at any time. Observations showed relatives talking with staff about the care their relative had received. 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 have access to 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. Some staff had received end of life care support and guidance from a local hospice. People were able to remain at the home and were supported until the end of their lives. Records showed that some people had requested to stay at the home until the end of their lives and hospital avoidance plans were in place to ensure that peoples' wishes were respected. 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. Records showed that peoples' end of life care had been discussed and advance care plans devised, however, some people had refused to discuss their end of life care needs and this had been respected by staff.

Requires Improvement

Is the service responsive?

Our findings

People were central to the care provided. People and relatives told us that they were fully involved in decisions that affected peoples' care. A visiting healthcare professional told us that the registered manager and staff were responsive to peoples' needs. People were supported to make choices in their everyday life. Observations showed staff respecting peoples' wishes in regards to what time they wanted to get up, what clothes they wanted to wear, what activities they wanted to do, what they had to eat and drink and what they needed support with. One person told us, "No one makes you do anything you don't want to, you choose". This was echoed in a comment made by a relative, who told us, "They know what their needs are, that comes from caring for them, they're comfortable, they don't push them to do anything". A healthcare professional told us, "I think this is one of the best care homes in this area, and I have no concerns. We have regular meetings with them and they are always keen to improve and take on any feedback. We are very happy with the way they care for people". However, despite these positive comments we made a recommendation to the registered manager to enable them to improve the provision of meaningful activities for all people.

Peoples' social, physical, emotional, and health needs were assessed prior to moving into the home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and people and relatives confirmed, that they had been involved in the development of the care plans. Regular reviews had taken place in response to people or relatives feedback as well as any changes in peoples' conditions and care was adapted accordingly. Care plans contained information about peoples' interests, hobbies and employment history and provided staff with an insight into peoples' lives before they moved into the home. However, it was not always apparent that this information was used to ensure that people had access to varied and meaningful activities.

The provider employed three activities coordinators who provided activity provision over a seven day period. Care staff could also be involved in providing stimulation and engagement and observations showed that during a quieter period some staff sat and talked with people. Activities that had been offered to people, who were able to take part, included pub lunches, arts and crafts, music for health, bingo, external entertainers and quizzes. People, who were able, told us that they enjoyed the activities. Comments included, "I like playing dominoes and the music exercises we do. We do hand jiving it really is good fun", "Someone comes in to play the keyboard from time to time. That's enjoyable" and "They try and tell you what's on, let you know so you can join in if you want". Observations showed some people engaging with technology to occupy their time such as I pads and handheld games consoles. Photocopies of photographs of warships that people had served on were also displayed in the foyer of the home with the person's name alongside.

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. We observed that there were differences between peoples' experiences for those who were living with dementia

and for those who were more independent and able to choose how they spent their time. Observations showed people, who were living with dementia, spent most of their time, sitting in armchairs watching television, sleeping or walking between one area of the home to another. A craft activity took place, facilitated by the activities coordinator and some people, who were able, were asked if they would like to participate. A visiting hairdresser was also available to style peoples' hair if they had requested it. However, not all people were able to take part in these activities and apart from quieter periods of the day, when staff were less busy and able to stop and engage with people, people were largely left to entertain themselves. A visiting healthcare professional told us, "I think there could be more activity for individuals. That person sitting down there by the door, they've been there a while but no one is sitting with them. When people are left that is often when negative behaviours can demonstrate unmet needs". Observations echoed this comment. One person, who was living with dementia, was seen walking around from one area of the home to another with little interaction from staff other than to ask the person if they were alright. We recommend that the provider seek advice and guidance from a reputable source, about the provision of meaningful activities, stimulation and interaction for people.

There was a complaints policy in place. Complaints that had been received had been dealt with according to the providers' policy and procedure. The registered manager encouraged feedback from people, relatives and staff, there were regular questionnaires sent to obtain feedback and leaflets were displayed advising people and relatives of a website where they could leave feedback about the home and the care provided. People and most relatives told us that they didn't feel the need to complain but would be happy to discuss anything with the registered manager. 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 and relatives praised the leadership and management of the home. They told us that the registered manager was supportive, approachable and friendly. One person told us, "The manager is approachable and happy to listen to you". A relative told us, "I think it's done very well, can't praise them enough". Staff working in the home were equally as positive, One member of staff told us, "Staff morale is good and we communicate well, this is a good place to work". However, despite this positive feedback, we found an area of practice that required improvement.

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. 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. The local authority also undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live. However, we found several examples of when the registered manager's and the providers' audits had failed to identify incomplete records. Records, in relation to peoples' care and treatment, were not always consistently maintained. For example, some people, due to being assessed as being at a high risk of malnutrition, had their weight and food and fluid intake monitored. However, records showed that these had not been completed consistently or in their entirety. Records showed that some staff had documented information about what people had to eat and drink; however there were often days when this had not been documented. Records for one person advised staff, 'Report to team leader if fluid intake becomes too low'. Not all fluid charts had not been totalled and therefore it was difficult to monitor the amount of fluid a person was consuming in a day. Fluid charts and associated nutritional care plans did not provide guidance for staff with regard to the recommended amount of fluid that a person should aim to consume each day so that staff could identify if the person was not consuming enough fluid.

Records for one person showed that they had been weighed each month since their admission four months previously. Each month the person had consistently lost weight. However, although the person had been referred to their GP and the living well with dementia team (LWWD), their weight loss had not been recorded in accordance with the providers' procedures for dealing with weight loss. When a member of staff was asked what should happen if someone continually lost weight, they told us that the person would be weighed weekly and have their food and fluid intake monitored as well as being referred to external healthcare professionals. However, this had not been implemented and records showed that the person had not been weighed on a weekly basis nor had their food and fluid intake been monitored consistently as there were only a small number of records and it appeared that this had been recorded sporadically. This meant that the person's weight loss was not being monitored sufficiently. When this was raised with the registered manager they took immediate action to ensure that the person was being sufficiently monitored and also devised a weight loss monitoring form so that staff could clearly and accurately have an oversight and monitor peoples' weight loss.

Reviews of peoples' care took place at regular intervals to ensure that peoples' care needs were being met

and to identify if changes were needed to their care. However, reviews had not always been sufficiently recorded and did not always identify any changes that had occurred to the person's care needs. For example records for one person stated that the person was able to mobilise with the support of their mobility aid, however the person's needs had changed and they were now being cared for in bed due to deterioration in their condition and as a result they were unable to independently mobilise. Records for another person informed staff that the person required the use of a stand-aid, this had been crossed out and it had been stated that the person now required the use of a hoist. However, observations showed the person being supported to use a stand-aid. Therefore there was sometimes unclear records and guidance to inform staff practice.

Some people, due to choice or their health, spent time in their rooms. There was a potential risk that these people could be socially isolated as they did not have as much access to staff interaction as other people who accessed the communal areas of the home. When the risk of social isolation was raised with the registered manager and staff, they told us that the activity coordinators, as well as care staff, spent time with people and engaged in conversations or activities with them. However, not all records to document meaningful interactions and activities for people were completed and therefore it was unclear if people had not been provided with stimulation and interaction or if staff had just failed to complete the records in relation to this.

The lack of documentation raised concerns regarding the care people received as it was hard to establish if people had received the necessary care or if staff had forgotten to accurately record their actions in peoples' records. This was of particular importance due to the high use of agency staff and the importance of ensuring that there are clear, accurate and up-to-date records for staff, who are unfamiliar with peoples' needs, to follow. The provider had not ensured that there was sufficient oversight of documentation to ensure that there were accurate, complete and contemporaneous records for each person. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Deerswood Lodge 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 units Ash, Beech, Cedar, Chestnut, Elm, Oak, Pine, Spruce and Willow have an individual team of staff. The home also contains a day service facility where people can attend if they wish, however this did not form part of our inspection. There was a relaxed and friendly atmosphere and people told us they felt at home and comfortable in their surroundings. One person told us, "It's quite settling once you get used to the noises". Another person told us, "I think it's beautiful and couldn't be better". A relative told us, "It felt right as soon as we came here. It was very welcoming and we knew our relative would be happy here". A visiting healthcare professional told us, "Generally I think this is a good home".

The management team consisted of a registered manager, two unit managers and team leaders. Staff told us that there was an open culture and that they were encouraged to seek advice or guidance from the managers who were happy to support them. One member of staff told us, "We work as a team and feel well supported by the senior managers. Another member of staff told us, "There is an open door policy and we use it". The provider, as well as the management team, valued staff and had implemented an initiative known as the STAR award. This was awarded to staff to reward and acknowledge the positive contributions they had made.

There were mechanisms in place to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving. This helped to ensure that people were receiving the quality of service they had a right to expect. There were good systems in place to ensure that

staff were provided with positive feedback or were made aware of any areas that needed improvement. The registered manager ensured that staff were shown and made aware of compliments and complaints that had been received. This demonstrated that the registered manager had a commitment to learning from incidents and used this to improve practice. It also enabled the staff to feel part of a team and share good practice with one another.

There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority, local hospices, LWWD team and other healthcare professionals. This ensured that peoples' needs were met and that the staff team were following best practice guidance. The registered manager attended senior management meetings and was supported in their role through these meetings as well as through regular supervision and support from their line manager who frequently visited the home. 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. The provider and registered manager ensured that practice complied with the duty of candour regulation. A sampling of some specific incidents showed that peoples' relatives had been informed, if the person gave their consent, when they had been involved in an accident or incident. The duty of candour regulation requires registered managers to act in an open and transparent way with relevant people who are involved in peoples' care.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Maintain securely an accurate, complete contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing. Regulation 18 (1) (2) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed.