Shawe House Nursing Home Limited

Shawe Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook this inspection of Shawe Lodge Nursing Home on 6 and 7 December 2016. The inspection was unannounced which meant the provider did not know we were coming on the first day of the inspection.

Shawe Lodge Nursing Home is located in Urmston, Manchester and provides nursing care for up to 41 people who live with dementia. Accommodation is provided on three floors. All bedrooms are single rooms and are accessible by a passenger lift. There is a designated unit on the second floor, which supports male residents only with complex needs. Communal rooms are available on the ground and second floors. There is an enclosed garden area and parking for several cars.

At the time of our inspection there were 41 people living at Shawe Lodge. This had steadily increased since our last inspection and the home was now at full capacity. A nurse form the Care Commissioning Group we spoke with said the home supports people with complex needs, some of whom have moved from other services who were not able to meet their needs.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a clinical lead.

At our last inspection in November 2015 we identified breaches of the regulations in relation to the administration and recording of medicines, accurate monitoring records of the care and support provided, consent, monitoring and mitigating environmental risks and not having an effective audit system.

At this inspection we found improvements had been made in some areas such as medicines management and consent. However we identified continuing breaches in monitoring records and the lack of robust audit systems in place to monitor and improve the service. New breaches were identified for staff training and regular checks on the fire alarm system were not being completed. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We have also made a recommendation about using best practice guidance to plan the environment suitable for people living with dementia and that all sluice, cleaning room and store cupboards are kept locked.

People we spoke with, and their relatives, were complimentary about Shawe Lodge. They said they felt safe, the staff knew their needs well and there were enough staff on duty to meet their needs. Staff were positive about their role.

Staff knew the correct action to take if they witnessed or suspected abuse. Staff were confident that the

registered manager or clinical lead would act on any concerns raised.

Care plans and risk assessments were in place with guidance for staff in how people wanted to be supported and the tasks they were able to complete independently. These were written in a person centred way and had been regularly reviewed and updated when people's needs changed. Care plans were in place for the support people wanted as they came to the end of their lives.

People we spoke with told us that the staff at Shawe Lodge were kind and caring. During the inspection we observed kind and respectful interactions between staff and people who used the service. Staff showed they had a good understanding of the needs of people who used the service.

Staff had received training, however this needed refreshing. Supervisions took place in response to an issue and were not planned throughout the year to support the staff team. Staff meetings were held for the ground floor staff team. A new unit manager had been appointed for the second floor and had started to engage the staff team to gain their ideas and input for the unit.

People received their medicines as prescribed and the nurses had received relevant medicines administration training. Guidelines for the use of 'as required' medicines were not always in place. Care staff added thickeners to food and drinks to reduce the risk of choking; however trained nurses signed the medicine administration charts.

Care plans and risk assessments were in place to help ensure people's health and nutritional needs were met. Monitoring records for food and fluid intake, personal care were inconsistent and not always completed in a timely manner. The layout of the lounge areas on the ground and second floors and the number of people using these spaces, especially at meal times, meant staff had to sometimes stand up when supporting people with their food because there was not enough dining facilities, especially on the second floor. This may be intimidating to someone living with dementia and shows a lack of dignity and respect. Records we reviewed showed that staff contacted relevant health professionals to help ensure people received the care and treatment they required.

We found the service was working within the principles of the Mental Capacity Act (2005). Capacity assessments and best interest decisions were made where required. Applications for Deprivation of Liberty Safeguards (DoLS) were appropriately made. Staff offered people day to day choices about their care and sought their consent before providing support.

All required checks with the disclosure and barring service (DBS) were made when recruiting staff and two references were obtained. However the gaps in one person's employment history had not been explored and accounted for.

An activities officer was in post at the home. Regular activities included an entertainer and a pub night. One to one games and crafts were undertaken with people. Memory boxes were being made to assist people to be able to identify their own rooms.

All areas of the home were seen to be clean. Procedures were in place to prevent and control the spread of infection. Improvements had been made in the management of clinical waste. Systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply.

Tests of the fire safety system had not been completed as planned since the service's handyman had left three months before the inspection. Maintenance of the home had also lapsed during this period. A new

handyman had started work at the home the week of our inspection.

A complaints procedure was in place. People we spoke with said the staff and registered manager dealt with any issues they raised verbally without needing to use the formal complaints process. This was confirmed by the staff and registered manager.

Audits were completed by the registered manager. However these were not consistently completed and were in response to issues identified by external audits and checks rather than being proactive and being used to drive improvements within the service. The registered manager said they were planning to have a set timetable for completing audits.

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 service was not always safe.

Regular checks of the fire alarm and fire doors had not been completed since the handyman had left the service in September 2016.

People received their medicines as prescribed. Care staff added thickeners to food and drinks but nurses signed the medicine administration charts. Guidelines for the use of 'as required' medicines were not always in place.

Sufficient numbers of staff were on duty to meet people's needs. Staff had risk assessments and guidelines to mitigate the identified risks.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was working within the principles of the Mental Capacity Act.

Staff said they felt well supported. We found refresher training courses and training for new staff needed to be arranged and supervisions were re-active to address identified issues and not planned throughout the year.

People received support to meet their dietary requirements. The space available in the lounges, especially on the second floor, meant staff often had to stand up when supporting people with their food, which people living with dementia may find intimidating.

Is the service caring?

Good

The service was caring.

Staff were kind and caring when supporting people. Staff knew people's needs well.

Staff maintained people's privacy and dignity when providing

support.

People's wishes for the care they wanted at the end of their life were recorded. The service had been awarded the 'Six Steps' award which recognises the support provided at the end of people's lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans gave detailed information to guide staff when supporting people.

Monitoring sheets were not completed in a timely or consistent manner.

An activities officer was in place who was organising a programme of activities for the home. Memory boxes were being made so people could more easily identify their own rooms.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had a registered manager in place as required by law.

Not all breaches identified at the last inspection had been remedied and a new breach in staff training and supervision had been identified.

Some audits were completed. However they were not completed on a regular basis, were often in response to external audit findings and had not identified the issues found at this inspection.

Surveys and meetings were undertaken to obtain the views of people living at the service and the staff members.

Shawe Lodge Nursing Home

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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 7 December 2016 and was unannounced on the first day. The inspection team consisted of two inspectors and an expert by experience on the first day of the inspection. 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 expert had experience of services for older people. One adult social care inspector returned for the second day of the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service including previous inspection reports, share your experience forms and notifications. A notification is information about important events which the service is required to send us by law. A share your experience form enables visitors, professionals visiting Shawe Lodge or staff to provide The Care Quality Commission with their views about the service.

We contacted the local authority commissioning and safeguarding teams as well as the local Healthwatch board.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period in the lounge areas of the home. SOFI is a specific way of

observing care to help us understand the experience of people who could not talk with us.

We spoke with 15 people who used the service, the registered manager, the clinical lead, two registered nurses and 11 care staff. We observed the way people were supported in communal areas and looked at records relating to the service. This included six care records, three staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People and their relatives we spoke with said they felt safe living at Shawe Lodge Nursing Home. One person said, "I'm quite at ease here." A relative told us, "[Name] is looked after well."

At our last inspection in November 2015 we found a breach of the Health and Social Care Act 2008 Regulations (Regulations) because medicines were not managed safely. At this inspection we found improvements had been made and this regulation is now being met.

The registered nurses had annual medicines administration training and we saw checks on their competency were made by the clinical lead through questionnaires and observations.

All medicines, including creams, were stored securely in a locked medicines trolley kept in a locked medicines room. Separate medicines rooms were used for the ground floor and second floor. The registered nurses were the only staff who had access to the medicines rooms. The nurses applied all medicated creams. However we did not see body maps in place to indicate where the creams needed to be applied. This meant a nurse new to the home or an agency nurse may not know where the cream is to be applied.

We found the Medicine Administration Records (MARs) were fully completed. Any handwritten entries, for example where a short course of medicines had been prescribed, had been signed by the nurse who had transcribed the instructions and also by another nurse who had checked that they were correct. We checked the quantities of four medicines and found them all to be correct and correspond to the quantity received and administered. This meant people's health was being maintained as they were receiving their medicines as prescribed.

We also checked that the controlled drugs were being stored and administered correctly. Controlled drugs are medicines where strict legal controls are imposed to prevent them from being misused. We saw they were stored securely and that two staff members signed in a controlled drugs register when controlled drugs were administered as required by law. This meant that controlled drugs were being administered safely.

We saw that some people who used the service were prescribed 'thickeners'. Thickeners are added to drinks, and sometimes to food, for people who have difficulty swallowing. They may help to prevent a person from choking. The thickeners were stored in their original containers in the kitchen so they were accessible only to the care staff. We saw clear guidelines were kept with the fluid monitoring charts for care staff as to the consistency each person needed. Staff were trained in the use of thickeners by the nurses. Staff ticked a fluid monitoring chart whenever drinks were provided however did not sign to state they had added the thickener. We saw the nurse signed the MAR sheets to state the thickener had been added four times per day; however people had more than four drinks each day. We discussed this with the registered manager and they said they would establish a monitoring sheet for care staff to sign when they have added thickeners to a person's drink.

We saw two people were administered medicines covertly. This means the medicines were added to their

food or drinks. The GP had signed a letter stating they agreed to the medicines being administered covertly and family members had also agreed. We saw staff made two attempts to administer the medicines before they were given covertly if they had been refused. This meant staff tried to administer medicines with the person's knowledge where possible and only used covert administration when they had been refused. We also saw the time one person's medicine was administered had been changed by the GP, at the request of the service. The individual preferred to get up late in the morning and the service had identified that they were missing some of their morning medicines. They requested that medicines usually administered in the morning were changed to lunchtime and the GP arranged this. This meant the service took relevant action when a person was not receiving their medicines as prescribed because they chose to sleep at the time they were meant to receive it.

Where people were prescribed 'as required' medicines, such as for pain relief, we saw guidelines were in place for some people but not others. The guidelines in place did not always state how the person would communicate, either verbally, through body language or behaviour that they needed the 'as required' medicines to be administered. Guidelines for 'as required' medicines are important so nursing staff know when the person requires them. We raised this with the registered manager and clinical lead, who said they would ensure the 'as required' medicines guidelines would be updated to include this information.

At our last inspection in November 2015 we found a breach of the Regulations because there were no risk assessments in place for people identified as at risk of choking. At this inspection we found choking risk assessments were in place.

We looked at six people's care files. We saw risk assessments were in place, including for falls, pressure ulcers, manual handling, challenging behaviour and nutrition using the Malnutrition Universal Screening Tool (MUST). These were reviewed monthly and updated as required. Where people had been assessed as potentially displaying behaviour that challenges a plan was in place to guide staff of the potential triggers and how to distract the person to diffuse the situation. Appropriate action was taken to reduce identified risks. For example, one person had had several incidents of challenging behaviour. Additional staff had been added to the rota to provide one to one support for the person to try and prevent any incidents reoccurring. This meant the service was identifying risks and taking action to mitigate these.

At our last inspection in November 2015 we found a breach of the Regulations because internal checks were not completed for window restrictors, emergency lighting, the environment and fire equipment as planned by the service. At this inspection we saw monthly checks had been completed. Records showed the equipment in the home, such as hoists, the lift and electrical items had been tested and serviced in line with the manufacturer's instructions. An emergency business plan was in place with contact information and guidance for staff to deal with any emergency situations such as a gas or water leak, heating failure or evacuation of the building. Personal emergency evacuation plans (PEEPS) were in place for each person. These detailed the support a person would require to evacuate the building and where they usually were at different times of the day, for example the lounge or their bedroom.

A fire risk assessment had been completed by an external company in February 2016. The recommendations made had been implemented, including completing weekly tests of the fire alarm systems. These had started after the fire risk assessment however we found the weekly fire alarm and fire door closure checks had only been completed on three occasions since September 2016 as the handyman had left the service at this time. A new handyman had been employed and they were completing their induction at the time of our inspection. We were told they would re-commence the weekly tests the following week. This meant the registered manager had not ensured the required fire safety checks had been completed during the period when the home did not have a handyman in place. This was a continuing breach of Regulation 17 with

reference to (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we made a recommendation about the service considering best practice guidance for the management of clinical waste. At this inspection we found improvements had been made, with waste disposal bins for personal protective equipment (PPE) being emptied regularly. A concern had been raised to The Care Quality Commission(CQC) by a relative about the cleanliness and tidiness of the home, including people's bedrooms. We saw the home was clean and free from malodours. We spoke with the head housekeeper who told us additional domestic staff had been recruited and the standard of cleanliness in the home had improved over the last three months. The cleaning records confirmed this, with more frequent cleaning of rooms and communal areas noted from mid-September 2016. We saw an infection control audit had been completed by the local authority in August 2016. The home achieved a rating of 'medium compliance'. We saw an action plan had been written following the audit. The actions had been completed within the agreed timescales and signed off by the registered manager.

The head housekeeper told us they completed daily spot checks to ensure standards were being maintained. We saw a record of a recent supervision meeting for one domestic member of staff where the standard of their work had been discussed, with areas for improvement noted. This meant the service had systems in place to maintain the cleanliness of the home and performance related issues had been addressed appropriately with the domestic staff.

We noted the sluice room and cleaning room on the first floor were not kept locked during the day. The head housekeeper told us this was because all people whose rooms were on the first floor spent the day either on the ground or second floor. On both days of our inspection we did not see people on the first floor; however there were no restrictions to people's movements within the home and these should be kept locked as there were chemicals and equipment stored in these rooms which were hazardous to people's health. We also saw a cupboard containing people's personal toiletries was open on the second floor landing. This meant people potentially had access to cleaning materials or toiletries which they could ingest. The sluice room on the second floor was kept locked so the people who lived on the second floor could not gain access to it.

We saw one room on the ground floor was used to store wheelchairs that were not currently in use. However the door for the room was left open. This meant people were able to access the wheelchairs, which if they moved could increase the risk of them falling.

The Control of Substances Hazardous to Health (COSHH) regulations state all cleaning rooms, cupboards, store rooms and sluice rooms are kept locked when not being used to ensure people cannot gain access to them.

During our inspection we noted the laundry had a lot of dirty laundry overflowing the linen baskets. We spoke with the laundry assistant who had started working at the service the week of our inspection. They said their colleague was absent due to sickness and there had been a brief period without staff cover in the laundry. They were working additional hours in order to work through the backlog. We noted there was not a backlog of laundry during the infection control audit in June 2016. We also saw the registered manager had spoken with the night staff to ensure they completed the laundry tasks assigned to them. This meant that although there was a backlog at the time of our inspection this was not usual and was being addressed.

We saw incidents and accidents were recorded and reviewed by the registered manager or clinical lead. Actions were identified; for example to make a referral to the dementia crisis team. The registered manager said they looked for any patterns or trends in the accidents or incidents such as the same person being

involved or having multiple falls; however this was not recorded. We saw one person had had repeated incidents with other people who used the service. One to one staffing for this person had been introduced to provide additional support to try to intervene and calm any potential incidents before they escalated. This meant the service had responded to incidents when they occurred to reduce the risk of them re-occurring but should introduce a more effective system for monitoring patterns and trends in the accidents and incidents and record the action that has been taken

We looked at three staff personnel files. The files we looked at contained proof of identity, two references and showed appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. This meant the people who used the service were protected from the risks of unsuitable staff being recruited. The files also contained an application form; however one of the forms did not detail the applicants' previous employment history. We asked the registered manager about this and they said they would explore and record any gaps in employment at the interview in future. We will check this at our next inspection. We saw the nurses' registration was checked with the Nursing and Midwifery Council (NMC). This meant the service had a system in place for recruiting suitable staff; however this required additional information to be gathered where there were gaps in people's employment history.

The people, relatives and staff we spoke with said there were enough staff on duty to meet people's needs. Our observations throughout the inspection confirmed this. The rota showed that there was a staff team for people living on the second floor who had complex needs and a separate staff team for the ground and first floors. We saw there was always a staff presence in the lounge areas on the ground floor. Staff were also detailed to spend time in the corridor areas to provide support for any people who liked to walk around the home. This showed there were sufficient staff employed by the service to meet people's needs.

Staff told us the number of staff on each shift had recently been increased as more people had moved in to the service. This meant new staff were being recruited. We saw from the rotas that the use of agency staff had reduced as more permanent staff members joined the service. A new unit manager had also been recruited for the second floor. We also saw that where required a block booking was made with the agency to ensure the same agency staff member worked at the home to cover the vacant shifts. This ensured continuity of staffing and enabled the agency staff member to get to know people's needs.

Staff were able to clearly describe the action they would take if they saw or suspected any abuse was taking place. They told us they would inform the nurse on duty, the clinical lead or the registered manager. We saw details of any safeguarding issues were kept, with a protection plan implemented where required. Any safeguarding issues were reported to the local authority and CQC. Records showed a safeguarding vulnerable adults training course had recently been held in October 2016. We saw some staff required the training to be refreshed and new staff needed to attend the course. We were told this had been booked and we will check that this was completed at our next inspection.

During the inspection we observed there were outstanding maintenance issues that needed to be completed. For example light bulbs needing to be replaced, a loose handrail was seen in the foyer, holes in bedroom doors on the second floor where old locks had been removed. We were told the handyman had left abruptly in September 2016. A new handyman had been employed and we saw they had started work the week of our inspection. The registered manager had a list of outstanding maintenance jobs to be completed. They said weekly maintenance reports were to be re-introduced to monitor the maintenance tasks required and completed each week. The handyman will be dedicated to Shawe Lodge whereas the previous handyman covered Shawe Lodge and its sister home. This should mean the home will have better support with maintenance issues in the future.

Requires Improvement

Is the service effective?

Our findings

The relatives we spoke with said they thought the staff had the right experience and attitude to meet the needs of their loved ones.

At our last inspection in November 2015 we found a breach of the Health and Social Care Act 2008 Regulations (Regulations) because a person who funded their own care had not received the support needed to make sure the decision to move to Shawe Lodge was the right one for them and best interest decisions were not clearly evidenced.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At this inspection we saw improvements had been made. Consent to care evaluations had been recorded and care plans were in place to guide staff as to the person's capacity to make decisions. We saw formal assessments of people's capacity to consent to their care had been completed by the local authority and applications for DoLS made.

We also saw best interest care plans, for example where people may refuse personal care or stand too close to other people potentially causing them anxiety. These detailed the decision to be made and guided staff on how to support the person in these instances.

We saw copies of any Lasting Power of Attorney were kept in people's care files. A Lasting Power of Attorney is a legal document giving another person the legal right to make decisions on a person's behalf if they are unable to make the decision themselves. This meant the service was working within the principles of the MCA.

Staff told us they received training relevant to their role, including infection control, dementia awareness and challenging behaviour. Training was a combination of external courses, accredited distance learning through the Northern Council for Further Education (NCFE) and on line courses. Staff also said they were supported to complete a relevant nationally recognised qualification.

New staff said they received induction training when they started working at the service. This included shadowing experienced members of staff, being introduced to people and having time to get to know them

and their needs. New staff had also been enrolled on the care certificate. The care certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. A new member of staff, who had started work at the home the week before our inspection, said they did not use the hoists or other equipment without the support of an experienced member of staff as they had not completed their moving and handling training. This had been booked for when the new trainer started working with the service.

The training matrix showed around 40% of staff needed to complete refresher training. For example moving and handling, infection control and fire training. Newly recruited staff needed to complete the training after being recruited; however one staff we spoke with had undertaken training in health and safety, moving and handling and infection control with their previous employer. This was confirmed by the registered manager. We were told the in-house trainer had left six months previously. We were shown that two people had been recruited to the role and then not taken it up. A new trainer was due to start work the week after our inspection and would provide training for Shawe Lodge and its sister home. During the time without an in house trainer the registered manager had organised some additional external training courses, but recognised that some staff were behind with their training. The new trainer will arrange for all outstanding courses to be completed, either internally or externally. We will check this at our next inspection.

This meant that refresher training was overdue and initial training for new staff was required.

Staff told us they felt well supported by the nurses, clinical lead and registered manager and spoke with them on each shift. One staff member who worked on the night shift said the registered manager worked a night shift approximately every three months so they could meet with staff and see the support people required at night for themselves. We saw supervisions had been completed with some staff. However we noted these were held when a specific issue needed to be discussed with the staff members, for example for night staff to complete the required laundry tasks. They were not held on a regular basis for all staff. Supervision meetings are important as they help staff discuss their progress at work as well as any learning and development needs they may have. We discussed this with the registered manager who recognised they needed to plan all supervisions throughout the year and not just use them to address performance issues. We will check that this is in place at our next inspection. We saw the registered manager had planned to complete staff appraisals during November 2016. However at the time of our inspection no appraisals had taken place. This meant that whilst staff felt supported by the management team and could approach them when they wanted to, regular supervisions and appraisals were not held.

We found the overdue refresher training and lack of regular supervisions to be a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we observed the morning handover between the nurse finishing the night shift and the nurse coming on duty for the day shift. This was a 'walking' handover where the two nurses went to each bedroom in turn and discussed any changes that affected a person's health or wellbeing. The incoming nurse also checked on each person and if they were awake said hello. However some people had woken early and were already in the lounge. The nurses spoke about them in front of other people in the lounge. This meant people's privacy was not respected and confidential information was discussed in front of other people. We raised this with the registered manager who said they would ensure information about people in the lounge was handed over in an appropriate manner in future. Written notes of the handover information were also made and kept for reference if required.

The day shift nurse then had a brief handover to the care staff coming on duty to work the day shift. They highlighted the people whose needs were different from usual; for example if they had not been well

overnight. Staff told us they received enough information from the handovers to support people. If they had any queries they would ask the nurse on duty or read the full handover notes. We noted a care staff member did this for one person who was agitated in the morning. The staff member said this may be because the person had not slept well the night before and was tired. They checked with the nurse and confirmed this was the case. The staff member then encouraged the person to have a sleep.

People told us they enjoyed the food at Shawe Lodge. One person said, "You can have what you want." We observed the breakfast and lunch experience at the service. The majority of people ate their meals in their chairs in the lounge areas rather than using the tables in the separate dining room or at the end of the ground floor lounge. People were able to have their breakfast from nine o'clock onwards. The lunch meal was usually a smaller meal, for example soup and sandwiches, with the main meal in the evening. On the day of our inspection the lunch menu was soup followed by quiche and a pudding. The portion sizes were adequate and people said it was tasty. However we saw the quiche was served on its own without any accompanying vegetables or salad. People were offered a choice of main meals in the evening. We were told if they did not want what was on the menu for that day people could ask for a different meal such as an omelette or jacket potato.

Where required, staff supported people with their meal. However due to the size of the lounges, especially on the second floor, staff had to stand in front or to the side of the people they were supporting to eat. This could be perceived as threatening by someone living with dementia. People on the second floor held their plates in their hand as they did not have a small table in front of them. This meant the meal experience was not relaxed or dignified.

We spoke with the deputy chef, who had joined the service a month previously. They had a good knowledge of people's nutritional requirements. The care staff noted on the menu choice sheets those people who required a soft or pureed diet. We saw plates were available with separate sections for each portion and a lip around the edge to assist people to eat independently.

The deputy chef explained they currently provided a vegetarian meal for one person and were able to meet different cultural needs if required. They were also in the process of reviewing the menus and asking people what they would like to have. Some new dishes had already been tried and had been well received.

We saw the latest food hygiene rating given in June 2016 by the local authority environmental health department was 2 (improvement necessary). We saw an action plan had been produced to address the identified shortfalls and these had been completed within the agreed timescales. For example the deputy chef had completed a 'safer food better business' booklet as required and a separate raw meat area was now used in the kitchen.

We saw people's weights were monitored, with most people either having a stable or increasing weight. When people lost weight we saw appropriate referrals were made to the Speech and Language Team (SALT) and dietician. The registered manager compiled a monthly audit of people's weights and what action had been taken if people had lost weight. Food and fluid monitoring charts were completed where required; however they did not detail the actual quantity of food or fluid consumed. The registered manager told us people's food and fluid intake was recorded when requested by the dietician.

We also saw referrals to health professionals were made when needed, for example the dementia crisis team. A medical professional we spoke with said, "I have no problems with the care provided at this home." Another told us the referrals made were appropriate and the staff followed the advice provided by the professionals. We were told, "The nursing staff have an insight and understanding of mental health."

Shawe Lodge is a purpose built home. However the layout of the lounges and communal areas of the home and their décor did not create a good environment for people living with dementia. The lounge areas on the second floor did not provide enough room for everyone to sit comfortably. At meal times staff had to stand over people to support them to eat their meals. One lounge area on the second floor was sparsely furnished and underutilised by people living on that floor. This meant the other lounge was overfull, especially during mealtimes. We saw two 'fiddle' boards were located on the ground floor corridors for people to use as they passed. Some blocks of brighter wallpaper had been used to break up the corridors. However on the second floor people had started to peel this off the wall. We saw some dementia friendly signs were in place on the bathroom and toilet doors. Memory boxes were used outside a few people's rooms so they could recognise which room was theirs; however more signs and memory boxes were needed to assist people to orientate themselves within the home. The doors on each floor were painted a different colour which would help to orientate people to the floor they were on. The registered manager told us the activities officer, who was new in post, was in the process of making memory boxes with people. However this was not an environment that promoted the wellbeing and independence of people living with dementia.

We noted the flooring had been replaced in most bedrooms. The registered manager told us they were planning to replace the carpets in the corridors in the next year.

Good

Is the service caring?

Our findings

Everyone we spoke with said the staff were kind and caring. One relative said, "The care is amazing here; [relative] settled here very quickly."

We spent time observing the interactions between staff and people living at Shawe Lodge on the ground floor and on the second floor as people were not able to tell us about their experiences themselves.

We observed many instances where staff treated people with kindness and respect. Interactions between people and the care staff were warm and positive. For example we heard staff asking people if they wanted assistance, patiently answering questions people asked them and chatting with people. Staff responded to people's needs in a timely manner. However on one occasion we saw one person spill some tea into their soup at lunchtime. The staff member supporting them mixed the tea into the soup and continued to support them to eat their meal rather than replacing this with a fresh bowl. This did not treat the person with respect. A professional who visits the service regularly said, "The informality of the staff interactions with people is good; they have a very caring approach."

Staff clearly explained how they maintained people's privacy and dignity. One staff member said, "I always talk with the person about the support I'm going to give them." One staff told us if the person did not want their support at that time they would respect their wishes and come back a little later and offer support again. We observed staff being discreet when discussing people's personal care needs with them. Staff knocked on people's doors and waited for a reply before entering. A professional who visits the service regularly said, "Staff maintain people's dignity when they provide support."

Staff knew the people they were supporting. One staff member on the second floor told us they judged people's mood before offering support with personal care. For example we saw one person had had a shave that morning whilst others had not. The staff member said they had offered the person a shave that morning as they had recognised they were in a good mood. This meant staff would offer people support with their personal care when they judged them to be in a receptive mood.

The care plans we saw for people who had lived at the service for some time included information about people's personal history. This included family members and details of their hobbies, interests and life history. One person had a completed Life Story booklet which provided detailed information about their likes, dislikes, jobs and things they had done throughout their life. The clinical lead told us this was a new booklet provided by the dementia crisis team. The service was planning to introduce the booklet for everyone. However we saw on the second floor two care files for people who had moved to the service one and two months before the inspection respectively did not contain information about people's personal history. This meant staff members had the information to form meaningful relationships with the people they supported; however it sometimes took time to compile this information after a person moved to the service.

We saw the service had just been awarded the 'Six Steps' award. The Six Steps end of life programme is a

nationally recognised award with the aim of enhancing end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. A nurse said, "We do a lot of the Six Steps already; it's good to update our knowledge and it sets out more recording and prompts to use best interest meetings when people can't say what they want at the end of their lives." We saw a record of people's wishes for the end of their life was in their care files. The person's GP and family, where appropriate, were involved when a decision not to attempt resuscitation was made.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2015 we found a breach of the Health and Social Care Act 2008 Regulations (Regulations) because monitoring charts, for example, food and fluid intake and personal care were not completed accurately and they did not always have people's names on them or the date they related to.

At this inspection we found a variation between the ground floor and second floor monitoring. On the ground floor we saw monitoring sheets for food, fluids, personal care provided and people's whereabouts in the home. However the food and fluid charts did not detail how much a person had eaten or drunk. The personal care records were not completed for all the people living at the home. For example we checked the records at 4pm on the 7 December and there were no records of any personal care for one person for the 5, 6 or 7 December. On the second floor we saw different templates were used to record when people were supported with turning in bed, with some records documented on company templates but others being recorded on hand drawn tables. We did not see any records of turns for the 4 or 5 December. We checked the hourly observations chart at 3.30pm and saw entries for the day of the inspection had been made for 8am, 9am and 10am only. We observed a person on the second floor asking for a drink and a sandwich at 10.15 in the morning. They were told they had just had breakfast and were only given a drink. On reviewing the food records in the afternoon we saw this person had refused breakfast and so had not eaten that morning. This meant that information was being recorded; however this was not always in a timely or consistent manner. When the information was recorded this was not always checked before making a decision.

This was a continuing breach of Regulation 17 with reference to 2 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed six care files and found they were written in a person centred way. They contained clear information about people's social care needs and preferences. The care plans contained guidance for staff on the support people required and what people could do for themselves.

Initial assessments were completed by the registered manager or clinical lead before people moved to Shawe Lodge. These gave brief details about the person's needs. An assessment completed by the relevant social worker or hospital was also in the care files. Staff told us they were given a verbal handover of a person's needs when they moved to the service.

The care plans were also made available for care staff to read and staff felt they were given sufficient information to be able to support someone who was moving in to the service. However one night staff member we spoke with told us they did not always get all the information they needed when someone moved to Shawe Lodge and it took them time to get to know what support the person required. Another night staff member said they received enough information from the nurses at handover to support people who had moved to the service. This indicated that not all night staff may be aware of all the support needs of a person, or the guidelines for providing support, immediately following their admission to the service.

The staff member also said that there had been improvements in the communication of relevant information to the night shift.

We saw a notice at the entrance to the home stating that any relative could look at and review their loved ones care plans if they wanted to. We were told relatives were asked when people moved to the home if they wanted to be involved in the assessments.

Detailed care plans and risk assessments were developed as staff got to know the person. We observed that the staff had a good knowledge of people's individual needs. Staff explained to us people's individual's needs, for example people who required support with pressure relief or had a soft diet due to the risk of choking.

A health professional told us, "The staff are knowledgeable about people's needs and how to manage people's challenging behaviour." Another health professional said, "The care planning here is good."

We saw care plans were reviewed monthly and updated when people's needs changed. This meant staff had the information to meet people's needs when they moved to the service or their needs changed. However communication of people's needs to the night staff was not always efficient.

We saw the nurses wrote the daily notes for each person. Staff told us they completed handover paperwork so the nurses were aware of the support each person had had during the shift.

The service had recently employed a new activities officer who had previously worked as a member of the care staff and so already knew people well. They were in the process of making memory boxes to go outside people's rooms. A weekly 'pub night' was held and regular entertainers visited the home. A relative told us the singer would visit their loved one in their room to play a song for them as they could not go to the lounge to watch them. The singer would also play some songs without their speakers on the second floor as some people did not like loud noise. The home also had a pet rabbit which people enjoyed petting. The activities officer also undertook games and craft activities with people on a one to one basis; for example playing cards. The activities officer was in the process of developing the programme of activities. However we were told that there were few activities arranged for people living on the second floor.

We saw the service had a complaints policy, with a copy displayed by the front door. We saw one complaint had been received in the last 12 months. This had been fully investigated, documented and responded to. The registered manager told us most issues people had raised were resolved verbally without the need for a formal complaint to be made. We also saw the service had received thank you cards from relatives.

We saw monthly residents meetings were held. The menus and activities organised at the home were discussed and people encouraged to make suggestions about what they wanted to be arranged. We also saw a survey was given to people who used the service in September 2016. Only three had been returned; the only concern raised was an issue with the laundry. We saw an additional staff member had been employed to work in the laundry and night staff had been reminded of their duties in regard to completing some laundry during their shift.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC).

All the people, relatives and staff we spoke with were complimentary about the registered manager. We were told they were approachable and would listen to, and act upon, any concerns raised. We saw the registered manager was visible within the home throughout our inspection. One relative said, "[Registered manager] was very caring and helpful when [relative] came here."

At our last inspection in November 2015 we found a breach of the Health and Social Care Act 2008 Regulations (Regulations) because the quality monitoring systems in place had not been robust enough.

At this inspection we saw that audits and checks were completed on a range of areas, for example medicines, care plans, monitoring people's weight and the environment. External audits had also been completed for fire risks, infection control and environmental health in the kitchen. Action plans had been agreed to address shortfalls identified in these audits and signed when they had been completed.

The operations manager for the provider also completed a monthly visit to the service. This included checks that actions identified in previous audits had been completed and noted changes at the service; for example the appointment of a new chef and handyman.

However we saw that the audits were not completed on a regular basis. For example a medicine audit had been completed in May, June and July 2016. The next audit was then in October and a further check made in November in response to a medicine error by an agency nurse. We saw the audit in July 2016 had noted 'as required' medicine guidelines were not in place for the people checked; however we found the guidelines for some people were still not in place at this inspection.

Two care plans had been audited in July, September and November 2016. There were 41 people living at Shawe Lodge at the time of our inspection which would mean it would take over three years to audit all the care files. The fire check audits were completed regularly up until July 2016 following the external fire risk assessment for the service. The only audit since then was in October 2016 which noted the handyman had left the service in September 2016 and the weekly fire checks were due to be completed by the handyman who worked at the provider's offices. However this did not happen as planned and further audits had not been completed that would have highlighted this.

We discussed this with the registered manager and clinical lead who told us they were planning to delegate some audits to the maintenance person, head housekeeper and clinical lead. The frequency of each audit and how many items, for example care plans, to be checked at each audit would be agreed. We will check that this is in place at our next inspection.

We saw minutes from safety and compliance meetings held with the operations manager, registered

manager and clinical lead. Four out of five meetings took place following issues being raised by external bodies, for example following the last CQC report and the infection control audit. The meeting in October 2016 addressed a staffing issue.

We found that the management team reacted when issues were raised with them, for example through the environmental health audit. Internal checks were then started and improvements were made within the agreed timescales. At this inspection we found improvements had been made with regard to medicines management, choking risk assessments were in place and following the principles of the Mental Capacity Act (2005). However there were continuing breaches of the regulations in relation to monitoring records and systems for auditing and improving the service. A new breach for staff training and supervision was identified at this inspection. With the home now being full we discussed with the management team about moving to a more pro-active approach with audits being regularly completed to check the quality of the service.

This meant a system of audits was in place; however they were not completed on a regular basis and did not identify issues found by external audits and inspections. This was a continuing breach of Regulation 17 with reference to (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff meetings were regularly held for the staff team on the ground floor. Staff confirmed they were able to raise any issues or concerns and make suggestions at these meetings. A new unit manager had just been appointed for the second floor. Staff told us they had been asked for their ideas on how to improve the support and activities available for the people living on the second floor. A staff survey had also been conducted in September 2016, with 19 replies being received. The comments made had been looked at by the registered manager and discussed with the operations manager. As a result of the survey comments, the hourly rate paid for staff working on the second floor unit with people with complex needs had been increased. This meant staff were involved in developing the service and the service took into consideration issues raised by staff.

Relatives meetings were advertised in the foyer of the home; however we were told few relatives attended these meetings as they spoke with the staff, clinical lead or registered manager when they visited their loved ones.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported correctly.

All the medical and social care professionals we spoke with were complimentary about the care and support provided at Shawe Lodge. One professional told us that the home supports people with complex and challenging needs in the second floor unit and manage their behaviours well. Another said, "The staff team are committed and knowledgeable about this client group."

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Overdue refresher training and lack of regular supervisions. Regulation 18 (2)(a)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance A system of audits was in place; however they were not completed on a regular basis and did not identify issues found by external audits and inspections. This was a continuing breach of Regulation 17 with reference to (2) (a) The registered manager had not ensured the required fire safety checks had been completed during the period when the home did not have a handyman in place. This was a continuing breach of Regulation 17 with reference to (2)(b) Information was being recorded; however this was not always in a timely or consistent manner. When the information was recorded this was not always checked before making a decision. This was a continuing breach of Regulation 17 with reference to 2 (c)

The enforcement action we took:

Warning Notice issued