Shaw Healthcare Limited

Deerswood Lodge

Inspection report

Ifield Green
Ifield
Crawley
West Sussex
RH11 0HG

Tel: 01293561704
Website: www.shaw.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
• Deerswood Lodge is situated in Crawley, West Sussex. It is a residential 'care home' registered for up to 90 older people, some of whom are living with dementia or frailty and other associated health conditions. At the time of the inspection there were 77 people living in the home.

People's experience of using this service:
• There were serious concerns about the care some people had received and the provider's lack of oversight to ensure that appropriate improvements were made.
• Risks were not always well-managed relating to choking and falling and there were concerns about people's safety.
• Medicines management was not safe. Three people had not always had access to medicines to manage their health condition in accordance with the prescriber's instructions. There was a risk that their condition was not well-managed and their mobility could have been affected. Medicines errors had occurred.
• Staffing levels were not always aligned to people's assessed needs. People, relatives and staff told us that they felt at times there was not sufficient staffing to meet people's needs.
• The provider had not always considered nor assessed agency staff's competence before they started work. There were a number of accidents and errors involving agency staff. Lessens had not always been learnt from accidents and errors.
• There were concerns about the lack of oversight and failure to make significant, timely improvements. Since the last inspection on 17 July 2018, the registered manager had left. For a temporary period, a new registered manager had led the home, who has also since left. The management team consisted of a deputy manager and an operations manager who was providing management oversight until a new manager was recruited. There was mixed feedback about the leadership and management. One person told us, "The management has been less than good recently." Another person told us, "The deputy manager is coping very well, she is easy to approach."
• The provider's values were not always promoted in practice. Concerns about people's care had not been rectified and improved upon in a timely manner to ensure people received the care they had a right to expect.
• Quality assurance processes had not always identified the concerns that were found at the inspection. When issues had been identified there had been insufficient action taken to ensure improvements were made.

Rating at last inspection:
• At the last inspection the home was rated as Requires Improvement. (Published 24 October 2018). The home had been rated Requires Improvement at the last three consecutive inspections.

Why we inspected:
• The inspection was brought forward due to information of concern that we had received in relation to people's care.

• At the last inspection on 17 July 2018, we found two breaches of regulations.
• At this inspection we checked the provider's progress. We found continued breaches of these regulations.

Enforcement:
• The overall rating for this home is 'Inadequate' and the home is therefore in special measures.
• Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
• If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.
• For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
• Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
• We will continue to monitor the intelligence we receive about this home and plan to inspect in line with our re-inspection schedule for those services rated as Inadequate.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-led findings below.

Deerswood Lodge

Detailed findings

Background to this inspection

The inspection:
• This focused inspection took place on 11 and 12 April 2019 and was brought forward due to information of concern that we had received in relation to people's care. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
• The inspection was undertaken by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
• Deerswood Lodge is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. People were accommodated in one adapted building, over two floors, which were divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge.
• The home had a manager who was registered with the Care Quality Commission, however they had recently left. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The management team consisted of a deputy manager and an operations manager who was providing management support until a new manager was recruited.

Notice of inspection:
• The inspection was unannounced.

What we did:
• We did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us to give us some key information about the service, what the service does well and

improvements they plan to make. This is because we were responding to potential risk and therefore had no time to request a PIR. We took this into account when we inspected the service and made the judgements in this report.
• We looked at information we held about the home including notifications the provider has sent to us about important events.
• We reviewed information sent to us from the local authority and members of the public.

During the inspection:
• We spoke with six people, one visitor, eight relatives, nine staff, the deputy manager and the operations manager.
• We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for ten people, three agency staff, quality assurance audits, incident reports and records relating to the management of the home.
• 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 observed the care people received as well as the lunchtime experience and the administration of medicines.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

• At the last inspection on 17 July 2018, we asked the provider to take action to make improvements. There were continued concerns that had not been improved upon since the last inspection. Risks to people's safety were not well-managed.
• Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of Safe. This was because medicines management was not always safe. One person, who was living with Parkinson's disease, had consistently not had their medicines at the prescribed times. Risks had not always been assessed or reviewed after incidents and this put people at increased risk of harm.
• At this inspection we continued to have concerns. The provider had not complied with their action plan or made the necessary improvements.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong:
• Risks to people's safety were not well-managed. Five people were assessed as being at high-risk of choking. Two people had been advised by external Speech and Language Therapists (SALT) to have a pureed diet. Guidance provided by the SALT had not always been followed. Both people were given non-pureed food. Records showed and staff confirmed, that they were consistently provided with sandwiches with soup poured over them for one meal each day. SALT guidance for one person advised to offer sips of a cold drink before eating and to provide food using a tea spoon to promote and assist the person to manage and swallow their food. Staff were observed not supporting the person in accordance with the guidance. A member of staff told us, "We pour the soup on top of the sandwiches and mash it up with a fork. For lunch all their food comes up from the kitchen as a puree but for supper everyone has sandwiches and soup." Despite both people being at an increased risk of choking and having access to high-risk foods, the provider had not assessed or lessened the risk. This was raised with the provider during the first day of inspection. However, despite this, communication with external social care professionals seven days after the inspection found that people who required a pureed diet were still having access to high-risk foods. This placed people at increased risk of harm.
• People at increased risk of dehydration and urinary tract infections (UTIs) had their fluid intake monitored. Staff had not always been provided with correct information about people's recommended daily fluid allowances. Records for three people showed that they had consistently had lower than the recommended daily fluid intake. Fluid intake charts were not always totalled or monitored to ensure people had sufficient fluids. When people's fluid intake was low it was not evident what action staff had taken to encourage further fluids. One person had experienced recurrent UTIs and other health conditions in relation to their continence which had required hospital admissions.
• Observations of people being offered drinks, as well as records for three people, raised concerns about people's access to sufficient fluids to maintain their health. Staff were seen offering people cups of tea

throughout both days of inspection. Some people were living with dementia and at times refused drinks. When this occurred, staff did not always offer any further encouragement to increase the person's fluid intake. The insufficient guidance, monitoring and action taken to ensure people had sufficient fluids, placed people at increased risk of dehydration.

• Before the inspection, the provider had informed us of an accident that had occurred. One person had been supported to use mobility equipment which had not been used in a safe manner and the person had fallen whilst using the equipment and had sustained an injury. Records showed that the person was supported by an agency member of staff. The provider was asked how they ensured agency staff had the appropriate skills to meet people's needs. They told us that their fulfilment team checked to ensure agency staff had training that the provider considered essential. Although records showed that the agency member of staff had undertaken moving and positioning training, the provider had not assessed the member of staff's competence before they started work to ensure that they knew how to operate equipment safely. This placed people at an increased risk of harm.

• Some people had been assessed as being at high-risk of falls and had access to equipment to minimise risk. Staff had been provided with appropriate guidance about how to support people safely. Two people however, were observed to be supported in an unsafe manner and not in accordance with the guidance. Guidance for one person advised that there needed to be two staff to support the person to use mobility equipment. The person was observed being supported by one member of staff.

• Before the inspection, a concern had been raised to us about staff's competence when using a piece of mobility equipment. Although the person could explain to staff how to use the equipment, staff told us that they had not been formally shown how to use this and that when they supported the person they were not confident in its use. There was an increased risk that the person might be supported in an unsafe manner.

• There was insufficient monitoring and action taken when one person had experienced unplanned weight-loss. One person had been assessed as being at high-risk of malnutrition. Guidance provided to staff advised the person should be weighed weekly, have their food and drinks fortified and have access to high-calorie snacks. Records showed and staff confirmed, that the person had not always been supported according to this guidance. At times the person had not been weighed for up to two months. There had been a continual decline in their weight. The person's food intake had not been consistently recorded or monitored to ensure that they had sufficient quantities to ensure there was no further weight loss. Although we were advised by the chef that some food had been fortified to increase the person's calorie intake, this was not always evident or consistent. When food that could not be fortified was on the menu, staff confirmed that the person was not provided with any additional snacks or fortified drinks, as had been advised in the guidance, to ensure they had sufficient calories to maintain or increase their weight. Instead, staff had relied on prescribed nutritional supplements rather than follow the guidance that had been provided by SALT.

• It was not evident that people at high-risk of sustaining pressure wounds had received appropriate care. Two people had been assessed as being at high-risk of pressure breakdown and had experienced reoccurring wounds. Staff had been provided with guidance which advised both people needed to be repositioned every two hours, have access to sufficient hydration and a nutritious diet to further minimise the risk. Records to document the frequency in which they had been supported to reposition, as well as our observations, showed that they were not supported in accordance with the guidance provided. On one occasion the person had not been supported to change position for five hours. This, as well as concerns about their access to sufficient nutrition and hydration, placed them at increased risk of further pressure area breakdown.

• Thickeners had been prescribed to thicken three people's drinks to minimise the risk of them choking. A patient safety alert issued by NHS England in 2015 advised about safe storage of thickeners to minimise the risk of asphyxiation by accidental ingestion. Despite this, thickening powder was stored in an unsecured kitchen cupboard next to some biscuits. Observations showed two people, who were living with dementia, within the area without staff support. There was a risk that they could have accessed the thickening powder.

• Following a serious incident, the provider had introduced a system to monitor people's health condition if

they experienced a fall and a head injury. When falls had occurred, however, the provider had not always learned from this situation to ensure people were appropriately monitored. Records for one person who had experienced a fall and head injury had not been maintained in their entirety. Staff were required to monitor the person for any specific changes in their condition for up to 72 hours after the fall. Records showed that staff had not undertaken all the required checks and there was a risk that if the person's condition had deteriorated staff may not have recognised this in a timely way to ensure the person received medical assistance.

• People did not always receive their medicines as prescribed. Relevant national guidelines about storing, administering and disposing of medicines were not always followed. Despite this being raised as a concern at the last inspection, we continued to have concerns about people not receiving their prescribed medicines at the correct time.

• Three people had Parkinson's disease. Records showed that these people had consistently had their medicines later than the prescribing guidance. According to Parkinson's UK, people living with Parkinson's disease need to have their prescribed medicines at specific times of the day otherwise there is a risk that their condition would not be well-managed and their mobility could be affected.

• The provider had not always ensured sufficient stocks of medicines. One person had experienced a fall and had sustained a fracture which had required a hospital admission. Once the person had returned home they had been prescribed a transdermal pain patch to manage their discomfort. Staff did not liaise or act in a timely way with other agencies involved in administering medicines when there were queries about the person's dose of medicine. Due to staff's uncertainty about the required dose and the untimely response, the person went without their pain relief for a period of 15 days. Therefore, there was a risk their pain was not well-managed.

• One person had been prescribed a pain-relieving cream for painful joints. This had been prescribed to be applied three times per day. Records showed and staff confirmed, that the medicine had not been in stock and the person had been without their pain-relief for a period of four days. Records for before this showed that the person had not been supported to have the cream applied as frequently as had been prescribed and therefore there was a risk their pain was not well-managed.

• One person who had stayed at the home for respite care, had not been given the correct dose of medicines during their stay. Once the person had returned home, their relatives had identified that they had not had access to their full dose of medicines to manage their health condition.

The provider had not ensured that people received safe care and treatment. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The environment and equipment was safe and well-maintained. Plans were in place to ensure people were supported to evacuate the building safely in the event of an emergency.

Staffing and recruitment

• There was mixed feedback about staffing. Three people told us there was enough staff to meet their needs. One person, two relatives and three members of staff told us that there was not sufficient staff to meet people's needs. People told us that staff were helpful but they sometimes had to wait to be supported with their personal care needs as staff were busy supporting other people. Comments in a recent residents' survey showed that insufficient staffing had been fed back to the provider.

• One member of staff told us, "Staffing levels have been poor and it makes it hard to juggle yourself." Another member of staff told us, "Staffing levels can leave people at risk if people are unsettled and one member of staff is covering two lounges. People's needs have changed and the home hasn't moved along with that."

• Some people needed two members of staff to support them. Staffing levels were not always aligned to people's needs. There was not always sufficient staff to meet the needs of others if staff needed to assist a

person who required the support of two members of staff. This meant that if a person required two members of staff to support them that one unit would potentially be left without staff support.
• One person told us, "The bell responses are slow." When the provider was asked for the records of staff's response times to call bells during one night, we were told that these were not available as the machine that recorded response times was not working on that occasion.
• People, relatives and staff told us that they had concerns over the suitability, experience and skills of agency staff. One person told us, "Some agency staff are not clued up." A relative told us, "The full-time staff are very good but the agency staff are not so good. My relative had to tell the agency staff how to put a catheter on." A member of staff told us, "Agency staff aren't always very good. Their training isn't always good." Another member of staff told us, "Agency staff are not aware of how to approach people which can escalate people's behaviours."
• Agency staff were observed to be task-focused and lacked the skills needed to interact and support people, particularly those living with dementia. They did not know people's needs and requirements and when asked were unable to tell us how people should be supported.
• There had been a number of incidents involving agency staff. This related to medicine errors, accidents and falls. The provider had ensured that the necessary recruitment checks were carried out before agency staff started work. A brief induction had been provided to orientate the agency staff if they had not worked at the home before. There were concerns, however, that agency staff lacked the appropriate knowledge of people's needs to support them effectively. The provider told us that it was the responsibility of agency staff to inform them if they were not confident in undertaking tasks and that they did not assess staff's competence before they started work. The provider had not assured themselves that agency staff had the appropriate skills to safely and effectively meet people's needs.
• Records to advise staff of people's needs and preferences were comprehensive. One agency member of staff told us that this made it difficult to find information and they had at one time struggled to find information to pass onto a GP when a person had been unwell. A shorter overview of people's care was provided, however, records showed that for one person this did not contain specific information about the person's care. As a result, an incident had occurred where the person was supported by an agency member of staff in a way that did not meet their assessed needs.
• The provider had not identified that there were a number of incidents involving agency staff. When they were asked how they monitored staffing in relation to incidents they told us, "It's not something that we track it is just about us making that connection." They explained that when an incident occurred the agency member was asked not to return to any of the provider's services. The provider had not considered that changes might need to be made to the way in which agency staff were inducted and supported when they started work to lessen the risk of incidents occurring.

The provider had not always ensured that there were sufficient and suitably trained staff to support people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Following the concerns raised with CQC prior to the inspection as well as those found at this inspection, CQC made safeguarding referrals to the local authority for them to consider under safeguarding guidance.
• The provider had reported alleged abuse to the local safeguarding team when it was identified. The local authority was making enquiries about on-going themes in relation to people's safety.
• Staff knew how to recognise abuse and how to protect people from the risk of abuse.
• People knew how to raise concerns if abuse occurred.

Preventing and controlling infection
• Infection prevention and control was maintained and the home was clean.

• Staff understood the importance of infection control. They used personal protective equipment and disposed of waste appropriately. This minimised the spread of infection and cross-contamination.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some Regulations were not met.

• At the last inspection on 17 July 2018, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of Well-led. There were continued concerns that had not been improved upon since the last inspection. The provider's own quality assurance processes had not identified the concerns that were found at the inspection. This related to insufficient monitoring and oversight of one person who had unexplained weight loss as well as one person's access to medicines. Records to document the care people had received were also not well-maintained, this was of particular concern due to the high-level of temporary staff used who did not know people's needs and requirements.
• The home was rated as Requires Improvement for a third consecutive time.
• At this inspection we continued to have concerns.

Planning and promoting person-centred, high-quality care and support; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care:
• We have concerns about the leadership and management. When concerns had been raised, the management team and provider had, at times, not been receptive and had not recognised the level of risk that people had been exposed to. There were continued concerns about the provider's oversight and ability to make improvements. Concerns found at previous inspections had not been sufficiently addressed or improved upon. For example, people's access to their prescribed medicines in a timely way and the management of risk. The provider had not ensured that they improved through shared learning of the concerns being found at some of their other services.
• There have been reoccurring themes throughout the provider's other services in relation to storage of thickening powders that could cause harm as well as medicines management for people who were living with Parkinson's disease.
• Delays in giving time-specific medicines to people living with Parkinson's disease has now been identified in six out of 12 of the provider's other services in the Sussex area.
• The unsafe storage of thickening powder for drinks that could cause people harm has now been identified in three out of 12 of the provider's other services in the Sussex area.
• Quality assurance processes were not always effective. Despite the untimely administration of Parkinson's' medicines being identified at the last inspection in July 2018, the provider had not introduced a way of appropriately monitoring this until February 2019. Although the manager's audits identified concerns about people's access to their medicines, changes to the way this was managed had not been introduced until March 2019.
• Audits on the timeliness of Parkinson's medicines were conducted the day after they had been given. This meant that no timely action could be taken to ensure that people had access to their medicines according

to the prescriber's instructions to lessen the potential effects on their health condition. Neither did it allow for later doses to be altered to ensure there was sufficient time in-between doses if an earlier dose of medicine had been given outside of the prescribing guidance.
• The provider has a dedicated quality assurance team who had conducted audits of the home on two occasions since the last inspection. They had not always identified the concerns we found about medicines management. When issues had been identified, there was insufficient action taken to ensure changes and improvements were made and people received their medicines on time.
• The provider's values of wellness, happiness and kindness were not always implemented in practice. Staff were observed sharing friendly interactions with people, respecting their choices, equality and diversity as well as their right to make decisions. However, the systems and processes within the home and the provider's response to concerns that had been raised in relation to people's care, did not always promote this practice.
• Since the last inspection on 17 July 2018, the registered manager had left. For a temporary period, a new registered manager had led the home, who has also since left.
• The management team consisted of a deputy manager and an operations manager who was providing management oversight until a new manager was recruited.
• Quality assurance audits had failed to identify trends in relation to a number of medicine errors and accidents involving agency staff. Neither had they identified that some people were not always being supported in accordance with their assessed needs and the guidance provided. When the provider was asked what action was taken when incidents involving agency staff had occurred, they told us that the staff were not used in their homes again. There was no reflection or learning from the incidents to improve the skills of agency staff such as undertaking competency checks before staff started to support people.
• There was a lack of oversight when people were at risk of dehydration. Staff were not always provided with accurate guidance about people's optimum daily fluid levels. When these had been provided, fluid intake charts showed that people had sometimes not had sufficient quantities to drink. This had not been monitored nor appropriate action taken to ensure that people's access to fluids was encouraged.
• Records to document the care people had received were not well-maintained or completed in their entirety. When people required support with their health condition, repositioning, food and fluid intake and weight to be monitored, records did not always document the care they had received. It was not evident if people had received appropriate care or if staff had failed to complete the required records.
• There was not a clear plan about how the service was planning to address the issues and make further improvements. The management team had attempted to make some improvements in response to concerns that had been raised in relation to medicines management and risk. However, these were not robust and did not ensure that risks were lessened and people received safe and appropriate care.

The lack of robust quality assurance meant people were still at risk of receiving poor quality care. The provider had not always lessened risks relating to the health, safety and welfare of people. Records were not always completed. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• Some staff, people and relatives were not complimentary about the changes in the management team within recent months. Some staff felt that there was low staff morale and told us that when they made suggestions these were not always listened to. One member of staff told us, "At the beginning of this year I felt the service wasn't well-led. We used to have regular staff meetings but it didn't matter what we spoke about nothing really changed." Another member of staff told us, "Can't always speak to management, it depends on the way the wind is blowing. We're spoken to like we're on the bottom of someone's shoe sometimes." One person told us, "Too many bosses here." A relative told us, "The management has been

less than good recently."
• Staff, people and relatives recognised that there had been changes in the management team and that within recent weeks the leadership and morale had started to improve. A relative told us, "The deputy manager is coping very well, she is easy to approach. The management has smartened up the place in recent months."
• Regular residents' and relatives' meetings ensured that people could air their views and discuss any ideas or suggestions. People told us that they felt listened to.
• The provider had worked in partnership with the local authority when there were concerns about people's care.

How the provider understands and acts on duty of candour responsibility:
• The provider had complied with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.
• People and their relatives told us and records confirmed, that the provider had informed them when there had been changes in people's 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 18 HSCA RA 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 people That staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

The enforcement action we took:

We have issued a Notice of Decision to impose conditions on the Provider's registration at Deerswood Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (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: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Maintain securely such other records as are necessary to be kept in respect of each service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

We have issued a Notice of Decision to impose conditions on the Provider's registration at Deerswood Lodge.