Walton On Thames Charity

Sherwood House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 24 May 2016 and was unannounced.

The last inspection took place on 19 May 2014 when we found no breaches of Regulation.

Sherwood House is a care home providing accommodation and personal care for up to 35 older people. At the time of the inspection 29 people were living at the home. Some of these people were having a temporary stay at the service and were due to return home or were making enquiries about a more permanent stay. Some people were living with the experience of dementia. The service did not employ nursing staff and any specific nursing needs were met by visiting community nurses. Sherwood House is managed by the Walton-on-Thames Charity, a charitable organisation set up to provide support and care for people living in the Walton-upon-Thames area. Sherwood House is the charity's only residential home; however they also provide support within two sheltered housing schemes.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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 and associated Regulations about how the service is run.

People told us they were happy at the home and liked living there. They found the staff kind, caring and supportive. People told us they would recommend the home to others.

People were sometimes placed at risk because the provider had not always assessed, recorded or monitored.

Although people found the staff kind and caring, we observed some care which did not show people respect. On some occasions the staff were focussed on the task they were performing rather than the person they were caring for.

People with dementia and complex social and emotional needs did not always receive the care and support they needed to meet these needs.

The records of care provided were not always accurate or up to date and therefore the provider was unable to monitor whether this care had met their needs.

People received medicines as prescribed but some of the practices around medicine recording, storage and administration were not always safe.

You can see what action we told the provider to take at the back of the full version of the report.

The staff were appropriately trained, supported and employed in sufficient numbers to meet people's needs.

The manager and provider were responsive to feedback from people who used the service, staff and others and had taken action to improve the service when problems were identified.

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

Some aspects of the service were not safe.

Risks to people's safety and wellbeing were not always assessed, monitored and managed.

People received medicines as prescribed, however some of the practices around storage, administration and recording of medicines meant that there was a risk of error.

People lived in a clean, well maintained and safe environment.

There were enough staff employed to keep people safe and meet their needs. They had been recruited in a way to ensure they were suitable to work with the people who lived at the service.

The provider's procedures for safeguarding adults were designed to reduce the risk of abuse and act swiftly when abuse was identified.

Is the service effective?

Good

The service was effective.

People had consented to their care.

People were cared for by staff who had the training and support they needed.

People's nutritional needs were met and they were able to choose from a range of freshly prepared food.

People were given the support they needed to stay healthy and see other healthcare professionals when required.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Sometimes the staff supported people in a way which focussed on the task rather than the person they were caring for and this care did not always show people respect.

People told us the staff were kind, caring and polite. We saw some kind interactions and the staff knew people well and were fond of them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People with dementia and those with complex social and emotional needs did not always receive the right support to meet these needs. Other people told us they felt their social needs were met and they enjoyed living at the service and socialising with others.

People's needs were assessed and care plans reflected individual needs and preferences.

People knew how to make a complaint and felt these were appropriately responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records to show the care which had been provided to people were inaccurate and incomplete and therefore the provider could not monitor whether this care had met their needs.

People using the service, staff and visitors felt the service was well-led and were able to contribute their ideas and comment on their experiences.

The provider carried out a range of audits and checks in order to monitor the service and to plan for improvements.

Sherwood House

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 checked whether the provider was 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 24 May 2016.

The inspection team consisted of two 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. The expert-by-experience supporting this inspection had personal experience of caring for someone who used services.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events. In addition, the provider sent us a Provider Information Return (PIR) in August 2015. The PIR 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.

During the inspection visit we spoke with 13 people who used the service, three visiting relatives and friends, one volunteer, two visiting healthcare professionals and the staff on duty, who included the registered manager, a senior care assistant, care assistants, kitchen and maintenance staff. We also spoke with the provider's director of residential services who was visiting the service on the day of the inspection.

We looked at records the provider used for managing the service, which included the care records for seven people, staff recruitment files for five members of staff, staff training and supervision records, records of accidents, incidents and complaints and the provider's audits of the service. We also looked at the way in which medicines were managed, which included observation of administration, storage and records. We observed how people were being cared for and supported. We looked at the environment, equipment within this and how this was maintained.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from risks because these had not always been assessed, recorded or managed appropriately. For example, we saw that one person who had been considered low weight and at nutritional risk had experienced significant weight loss. The provider's risk assessment did not accurately record this and the care plan for this person did not record all the actions needed to monitor and increase the person's weight. Another person had been assessed as at risk of choking and was prescribed thickener for their drinks. However, their care plan referred to them liking foods which would increase the risk of choking, such as toast. During lunch the person was not observed whilst they ate and when they started to cough the staff were slow to respond and check the person was not choking.

The care plan for another person indicated that they were at high risk of falling. There was no record to indicate the person had seen a healthcare professional about their falls or been referred to a falls clinic who would support the staff to think of ways of reducing risks of falling.

One relative told us they were concerned that their family member had fallen from bed and hurt their head. They told us the provider had supplied a crash mat on the floor by the bed, however, they felt other options had not been explored. We discussed this with the manager, who said that they had considered other options and felt this was the safest way to reduce the risk of injury for the person. However, they had not discussed this with the person's family and the different options had not been recorded as assessed. The provider had not consulted another healthcare professional about the decision and therefore it was not clear whether this was the most effective way to manage the risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines as prescribed. However, some of the practices around medicines meant that there was a risk of errors occurring. For example, medicines were stored in a locked room, however, a glass panel above the door to the room had been removed, meaning that the room was not completely secured. It was unlikely that someone could enter the room through this missing panel and the provider stated that they did not believe this was a security risk.The temperature of refrigerators where medicines were stored was recorded, but the room temperature was not measured and the staff told us this room could become, ''Very hot.'' The properties of some medicines can be altered if they are stored at temperatures which are too high or low, and therefore there was a risk of this happening without the staff knowing because they were not monitoring the temperature. Some of the medicines, such as topical creams and liquid medicines, were not clearly labelled with the date of opening. This could mean people were at risk because the medicines properties were altered after a long period of time in use. Following the inspection, the manager told us that all medicines were renewed every 28 days.

The manager told us that wherever possible people were encouraged not to bring their own homely remedies (non-prescribed medicines). However, we noted that one person purchased their own homely remedy. One of the person's prescribed medicines came with a warning against the use of one of the

ingredients in the person's homely remedy. The staff told us they had checked whether the homely remedy could be used with the pharmacy who they said had confirmed the medicines could be used together. However, there was no record of this and therefore the provider could not evidence they had appropriately assessed and managed this risk.

There were no protocols regarding the use of PRN (as required) medicines. Therefore the staff did not have guidance about when they should and could administer these medicines. For people who were prescribed pain relieving medicines there was no record about how they would express their pain when they were unable to do this verbally. Therefore people were at risk of not receiving medicines when they needed them or receiving medicines wrongly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine administration records were completed accurately and included information when a person had not taken their medicines as prescribed. There was information about the person, their date of birth, allergies and any medical needs stored with administration records.

We observed people being administered medicines in a safe way. The member of staff responsible for this had a dedicated time away from other tasks. They could be clearly identified by a coloured tabard so they were not disturbed. They explained what they were doing and allowed the person to take their time, providing a drink when needed. The senior staff, who were responsible for administering medicines, received training in this and the training was regularly reviewed and updated.
People living at the service and their relatives told us they felt safe at the home. They told us staff were attentive and available when they needed them. One person said, "Oh yes I do feel safe living here; they are always coming in. I don't have a problem with any of them." A visitor told us, "[My relative] is in the best place to be safe; there is someone here overnight."

The provider had a procedure for safeguarding adults and information about this was available for the staff. All of the staff had received training in safeguarding adults. The care staff were all able to tell us what to do if they suspected someone was being abused. They knew they should speak with the manager and local safeguarding teams. However, some of the other staff (not providing care) were not confident about what they would do if they wanted to report suspected abuse. The manager told us that they would arrange additional supervisions and discussions to help these staff understand what their roles and responsibilities were. The provider had responded appropriately to an allegation which they had received. They had worked with the local authority to investigate concerns and take action to keep people safe.

The provider had equipment for hoisting people who required this. The staff had been trained in manual handling techniques and their competency in using the equipment had been checked. People had their own individual slings which were used with the hoists. These were labelled and stored in their bedrooms. There was evidence that this equipment was regularly checked.

The building was clean and odour free throughout. The provider employed cleaning staff who worked full time at the service. There were regular infection control audits and checks. Chemicals and cleaning products were stored securely. The laundry room was well organised and maintained with systems for managing clean and soiled items. However, we noted that there was build-up of dust behind the washing and drying machines.

There was a fire risk assessment which had been completed in 2014. The manager told us there had been a

recent reassessment but they had not yet received a copy of the report. There were individual evacuation plans for all the people who lived at the service. These included information on how the person would respond in event of a fire and the support they would need to evacuate. The provider carried out regular checks of fire safety equipment and fire drills. These were recorded.

The provider ensured appropriate checks were made on the safety of the environment and equipment. These checks included checks on window restricting devices, beds, hoists, electrical safety, water temperatures and safety and the gas supply. There was a record of checks and action taken when concerns were identified.

There were enough staff employed to keep people safe and meet their needs. The provider employed senior care workers to organise how other staff spent their time. At the time of the inspection the staffing levels were one or two senior care workers with five care workers each day and three members of staff, including a senior member of staff, at night. The manager and provider's senior managers also worked at the service throughout the day. There were dedicated kitchen, laundry, cleaning and maintenance staff who were not responsible for delivering care.

The manager told us the provider used some temporary staff to cover staff absences. They said they tried to use the same temporary workers who were familiar with the home. The provider had information about each of these workers, including their relevant training, qualifications and experience.

The majority of staff had worked at the service for a long time and there were rarely changes in the staff team. One visitor told us, "The staff have not changed, they rarely leave and there is consistency. Even the maintenance man has been here a long time."

The provider had appropriate systems to ensure only suitable staff were recruited to work at the service. These included making checks on references from previous employers, criminal record checks, eligibility to work in the United Kingdom and checks on identity. The staff records kept by the provider included evidence of these checks and also of recruitment interviews. On the day of the inspection the provider's director of residential services and senior care staff were conducting staff recruitment interviews.

Good

Is the service effective?

Our findings

People had been consulted about the way their care was planned. People who had been assessed as having capacity to make decisions had signed agreement or given verbal consent to their care plans. We saw records of this. Where people had been assessed as lacking capacity, their care plan had been discussed with their next of kin, or other representative. These representatives had signed to show they understood and agreed with the plans.

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.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager confirmed that there was no-one currently deprived of their liberties at the service, although they were aware of the action they would need to take if someone was.

The staff told us they felt supported and had the training they needed. New staff completed an induction which included shadowing existing staff and taking part in a range of training. Training was regularly reviewed and updated. The provider used an external training company who visited the home and ran classroom based training, tests and assessments. New members of staff completed training for the Care Certificate, (this is a set of introductory standards that health and social care workers adhere to in their daily working life to provide compassionate, safe and high quality care and support). We saw evidence of staff training. The manager monitored this to make sure training was up to date.

The staff told us they worked well as a team. They said that they discussed people's needs and changes in the service each day during a handover of information which the senior care staff. The staff had individual meetings with their manager every three months to discuss their work, any training needs and career development. Once a year, the staff took part in an annual appraisal of their work. These were recorded. There were also regular team meetings for each department, where the service, key procedures and changes were discussed.

All bedrooms had an en-suite toilet and wash basin and some had en suite showers. The rooms were equipped with adjustable height beds, fitted wardrobes, a chest of drawers and televisions. People were able to bring their own personal belongings and furniture and were encouraged to personalise their rooms. The building was designed creating clusters of six bedrooms and a seating area. There were additional communal rooms, a secure garden and an accessible allotment which was situated opposite the home. The

home was open plan and there was a mezzanine area making the communal rooms light and airy. There were assisted bathrooms and showers, some if these had been refurbished in the past year. Corridors, bathrooms and toilets were equipped with hand rails. The home had underfloor heating, meaning that there were no hot radiator surfaces. Bedroom doors were identified by numbers and bathrooms and toilets doors were yellow. There were no restrictions for people moving around the building, although the front and back door were secured with numerical key pads. We saw people moving around the home and using different seating areas to relax throughout the day. One of the visitors we met told us they liked the fact there were so many different seating areas where people could entertain visitors, the said, ''It really is lovely here.'' There were large pictorial notice boards with planned social activities and the menu on display.

People told us they liked the food at the service. Some of the comments included, "The food is very good'', "I think we're thoroughly spoilt [with food]. Whatever we have it is beautifully cooked", ''Yes I really like the food it is very good'', ''The food is hot and tasty'' and "They bring me breakfast at 8:30; I have porridge and toast in my room. I eat my other meals in the dining room… I like [the food].''

Throughout the day the staff offered people cold and hot drinks, offering to refill cups when someone finished what they were drinking. The staff encouraged people to drink and reminded people who had left their drinks untouched. There were also water coolers and cups available throughout the building for people to help themselves.

People's nutritional needs were assessed and care plans were in place where people were considered at nutritional risk.

The kitchen was well maintained, clean and organised. The kitchen staff took daily temperatures of food storage areas and the food when it was served. There was a good stock of fresh fruit and vegetables as well as dried goods. The kitchen had been inspected by the Environmental Health Office on 8 June 2015 when they had been awarded a five star (the highest) rating for hygiene.
The menus were planned on a four week rotational basis, offering two main choices for each meal. The cook told us that people were able to ask for alternatives if they did not want or like the main choices. The kitchen staff prepared all the meals each day and also snacks, including a selection of sandwiches, for people to access during the evening, night and early morning.

The kitchen staff had information about people's dietary needs, for example allergies and special diets. However, these did not always include the reasons why people had special requirements and the kitchen staff were not aware of these reasons. For example, they knew that one person should be encouraged to drink milkshakes but they did not know that this was to help increase their calorie intake. Changes in dietary needs were communicated with the kitchen staff, but they did not have regular meetings to discuss these.

The kitchen staff told us their aim was to, ''Keep the kitchen clean, serve good food and keep the residents happy."

People's healthcare needs were recorded in their care plans. The information included details of the various healthcare professionals supporting the person. Changes in people's health were monitored and recorded. Care plans had been updated to reflect these changes. There was evidence of regular consultation with healthcare professionals which included their recommendations and advice.

Most people were able to retain their own GP when they moved to the service. The manager told us they encouraged this unless someone had moved from a long distance away. One person confirmed this telling us, ''Everyone is able to keep their own doctor.'' People told us they were able to see their doctors whenever

they needed. On the day of the inspection one person told us they felt unwell, they said, ''If I still feel unwell later the staff will call the doctor for me.'' They said that the staff were very responsive and communicated with healthcare professionals as needed. Another person told us about when they had fallen. They said the staff had called emergency services who had attended promptly and reassured them. One relative told us that the manager had encouraged them to attend when the visiting community nurses carried out a consultation with their family member, so that they could reassure them and ask any questions they needed.

The manager told us the staff had a good relationship with healthcare professionals who supported people. For example, they told us they were regularly in touch with the community mental health team who assessed and supported people. There were two visiting hairdressers and two visiting podiatrists and people made their own private arrangements for these services.

We spoke with two visiting healthcare professionals, a community nurse and a member of the palliative care team. They told us the staff worked well with them meeting people's health needs. Both professionals regularly visited the service. They told us the staff highlighted any concerns regarding people's health and changes in need. They also said the staff followed their guidance. The community nurse told us the staff provided good skin care, monitoring changes in skin contrition and taking action to prevent pressure areas and wounds. The professionals comments included, ''This is a good service'', ''The staff get everything ready and are very helpful'' and ''The staff connect well with the GPs and there is good communication.''

Requires Improvement

Is the service caring?

Our findings

One person told us, ''One or two carers really help me, but one or two are not good at all, when I ask for something they tell me they cannot do that now as they are busy or they say they cannot stop to help me. They tell me to ring the buzzer but when I do the carers just come and tell me they will help me later, I think they think I am lazy.'' The person went on to say that sometimes the staff did not always make sure the person was happy when they provided care. They told us, ''The little thinks irk me, such as when they bring me a cup of tea, they do not put the sugar within my reach even though they know I like sugar in my tea.'' Another person told us, ''They are always in a rush, they bring me my dinner but then they leave to serve other people before coming back to help me, and I need my food cut up before I can eat it.'' We observed this to be the case during lunch time service. The staff put plates of food in front of people but then went on to serve everyone else before returning to the people who needed support. We saw that one person who was unable to eat without assistance was left with a plate of food in front of them for several minutes.

Some of the interactions we observed did not show people respect and the staff were focussed on the task they were performing rather than the person they were caring for. For example, during lunch, three different members of staff supported one person with their meal. Each member of staff left the person without explaining what they were doing or that someone different would be caring for them. Another member of staff who was supporting one person kept leaving the table to attend to other tasks in the middle of the meal. They did not explain what they were doing or speak with the person when they returned to the table. At the end of the meal the staff supporting people walked away without telling the person the meal had finished. The staff supporting people hardly spoke with them. When they did speak they discussed the task they were performing but did not speak with the person about their feelings or experience.

Before the meal started the staff placed protective tabards on people without asking them whether they wanted this or informing them they were placing this on them. In some instances the staff approached people from behind to place the tabard on the person without any communication. People were not given a choice of drinks. The manager told us that people were usually offered a choice of drinks each day which included squash, water and lemonade.

Immediately after finishing their lunch people were asked what they wanted to eat for supper. Many of the people who were asked were confused about this and several of them thought they were being offered the supper food at that point in time. The member of staff asking people often made the choice for them, given the person only one option and then stating, ''You like that don't you?'' before the person had a chance to respond. Although there was a pictorial menu on display, the staff did not use pictures to help people to understand the choices. When food was served at lunch time it was already plated and people were not given a choice whether to have gravy or if they wanted sauce or other condiments. One person requested salt on their meal and the staff assisted them to have this, but other people were not offered this. During lunch there was a planned test of the fire alarms. The staff approached the inspection team to warn them of this but none of the people who lived at the home were warned and we saw one person flinch when the alarm was sounded.

After lunch the staff placed a trolley containing dirty plates and uneaten food next to people whilst they scraped their left overs onto this. Some people were still eating their food whilst this happened.

The staff did not always use language which showed respect for people. They referred to ''Feeding'' people, ''Creaming'' them and ''Toileting'' them rather than speak about supporting them. At one point we heard a member of staff call someone a ''Good girl.''

We witnessed a number of occasions where the staff discussed the people they were caring for and other people living at the service over the top of people's heads. On one occasion two members of staff standing on opposite sides of a room were discussing people who used the service. We also observed that the staff who sat with people did not always communicate with them. For example, during the afternoon a group of people were seated in one lounge. The member of staff sitting with them did not speak with anyone. However, when another member of staff entered the room they had a conversation with each other about something unrelated to the service.

The staff did not always consider people's individual needs when supporting them. For example, one person who was seated at a dining room table was moved to a different table by the staff. The member of staff told them, ''This is where you have your lunch.'' However, there was no reason for this person to be moved and they appeared confused by this.

The care notes the staff recorded to show how they had cared for people listed the tasks they had performed but did not record how the person felt or if their social and emotional needs were met.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people told us they thought the staff were kind, caring and polite. Some of the comments from people included, "It is lovely here. They have been ever so kind and lovely. I can't praise them enough", "I have a good life [here]", "I tell everyone about [this care home]. This is 100% for me. I can't fault it", "I think they look after us very well. They are very kind…. I would definitely recommend [the Home] to a friend", "It's very good here. I have no complaints at all. It's marvellous" and "It is fairly good I think, I would give them 7 out of 10." One relative told us, "[My relative] is looked after well and they are kind to her.'' Another visitor said, "All the staff are so nice, they are very well aware of people's needs and responsive." The visiting health care professionals told us the staff were friendly towards the people who they were caring for. One of them said, ''This really is a fantastic home, the staff are so caring.'' The other professional told us, ''The staff have good communication with the residents, they care for them very well, it is a very good service.''

One person told us they thought the staff were kind but they did not always know what was happening and this made them anxious. They told us they were not always reassured by the staff.

We observed some interactions which were kind and caring. The staff bent down to speak with people at their eye level. They reassured them and comforted them when they were distressed. The staff were polite towards people and addressed them using their preferred names. The staff knew people well and knew their individual preferences and interests. When the staff spoke about the people they cared for they spoke about them fondly, telling us they ''loved'' caring for people and that they wanted to care for them as if they were their family. The way the staff approached people showed kindness and compassion. No one was rushed or made to do something they did not want to do. Privacy was respected when the staff delivered care. For example, we saw the staff knocking on bedroom and bathroom doors, asking permission to enter rooms and providing care in private.

People were well dressed, clean and fresh. People wore their own clothes which were regularly laundered. People had regular baths and showers. One of the members of staff said, ''We let people decide when they want to have a shower, if they want three showers a week or one a day that is fine, we can provide that.'' One of the visitors we met told us, "The staff obviously enjoy making [our friend] look nice, dressing her in nice clothes, colour-coordinated, put on her jewellery and dressing her nicely."

People were supported to maintain their independence as far as possible. For example, they were provided with special equipment to make it easier to eat their meals without assistance. One person told us, "I look after myself as much as I can. I can wash and get myself to bed. I try to be independent and they encourage this.''

Requires Improvement

Is the service responsive?

Our findings

The atmosphere at the service was calm and relaxed. Small groups of people socialised and played games. On the day of our inspection a group of five people were playing a game of scrabble with a volunteer. We observed a good camaraderie between some people who enjoyed each other's company. However, there were limited social activities and facilities for people with dementia. For example, people were not offered activities to be involved in, items to hold or anything to do apart from when they were eating or given drinks. In the morning people with dementia and higher needs sat in the lounges and dining rooms with a drink. The staff did not spend time engaging with them apart from to offer them drinks. After lunch the majority of people were taken to a lounge where they sat with the television on. There was no alternative activity and no conversation, except that between the staff. Whilst there were books and games available for people who could use these, there was no equipment, toys or activities available for people who no longer had the skills to read or play complex games. The advertised activities did not take account of the different needs of people.

The care records to show the social activities people had participated indicated that there was little or no variety, with some people's only recorded activities as either watching the television, listening to the radio or chatting for 2016. Although for the majority of days there was no recorded activity for three of the people whose care plans we viewed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us they enjoyed the organised social activities. Some of their comments included, "It is very nice here. There's always something to do and someone to talk to", "Sometimes we go upstairs and do poetry in the afternoon", "We had armchair exercises yesterday and on Sunday afternoon four ladies from the Methodist church came in to sing hymns. I heard the music and I was drawn to it" and ''I enjoy our games of scrabble.''

One visitor told us, ''I have not noticed many outings recently but there is a lot of singing, music, a clothes sale recently, we're all invited, a party in the summer and Easter bonnets.'' The manager told us they hosted two parties each year for friends and families.

The charity had an amenity's fund which provided funding for outings including a regular lunch club, where people were able to visit local pubs and cafes for a meal out together. The provider owned an allotment which was situated opposite the home. This was wheelchair accessible and had seating overlooking other allotments. The manager told us people were involved in growing their own vegetables and herbs which were used in meals at the service. The garden had raised beds. One person who lived at the service told us how they helped to maintain these.

People told us their care needs were being met at the home. They said they had been involved in planning their care and relatives confirmed they had been consulted. However, one person told us their next of kin

had recorded detailed information about their needs to accompany their care plan but they did not think the staff had read this.

People interested in moving to the service were given information about Sherwood House, the provider and the services and care they could expect. People's needs were assessed and recorded in care plans. The care plans included a one page profile which outlined the things which were important to the person and what people liked and admired about them. The care plans were clear and included preferences and details about individual needs and how the staff should meet these.

People told us they knew how to make a complaint and felt these would be listened to and acted upon. One relative commented, ''I would feel comfortable raising concerns if I had any.'' People told us they did not feel they had cause to complain and they were able to speak about any concerns they had informally. The provider had a complaints procedure and people were given a copy of this when they moved to the home. Information about complaints and local services, such as the local authority, were on display around the home. The manager had a record of complaints. We could see evidence that action had been taken to investigate these and provide feedback to the complainant about the outcome and action taken to improve the service.

Requires Improvement

Is the service well-led?

Our findings

People told us they thought the service was well-led. One person told us, ''They are improving the place, modernising it. It's clean. Cleaners always around, a well looked after place." A visitor said, ''[My friend] used to live in another home, that is no comparison. It is so much better here.''

Some of the records the provider kept were inaccurate or incomplete and did not give a true picture of the care provided to people living at the service. For example, we looked at the care records for seven different people. There was no record to show that five of the people had been weighed since February 2016. Two of these people were on fortified diets because they were considered at nutritional risk and therefore recording and monitoring their weight was an important part of ensuring they were receiving the right care. The record for one person indicated that staff may have recorded the wrong weight one month, however, there was no evidence that this had been followed up and the correct weight recorded. The nutritional risk assessments for each person including adding up a score of different factors to determine the level of nutritional risk. We noted that in one person's assessment they had calculated the wrong score and therefore had an inaccurate picture of the person's needs.

The records to show whether people had received baths, showers, had their hair washed and bed linen changed were incomplete. In one case indicating a person had only been washed 11 times in May and 12 times ins April 2016. The record indicated that they had had their teeth brushed eight times in April 2016 and not at all in May 2016. In another person's care notes there were 11 records that the person had a wash in May 2016, no records of any baths or showers in 2016 and no record of bed linen being changed since March 2016. People living at the service, the staff and the manager told us that baths, showers, bed linen changes and taking people's weight did happen, but that the staff had not accurately recorded these. Therefore the provider was not able to accurately monitor the care provided to people to ensure this reflected their preferences and met their needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had worked at the service for four years and was registered with the Care Quality Commission. Before working at the service, they had experience working as a registered manager and other roles within residential and community services. They had an appropriate management in care qualification. The staff told us they liked the manager and found them approachable and supportive. One member of staff said, ''[The manager] is always there if I need her, I can talk with her about anything and she helps when I want advice.'' Another member of staff told us, ''I am very happy with my manager, she never minds if we need help.'' One of the visitors we spoke with said, ''I think the service is well managed, [the administrator] is lovely, very amenable and the manager is approachable and I can speak to her if I need.''

Walton-on-Thames Charity is a charitable organisation set up to provide support and care for people living in the Walton-upon-Thames area. Sherwood House is the charity's only residential home; however they also provide support within two sheltered housing schemes. The manager told us that the senior managers from

the organisation were supportive and they could ask for assistance whenever needed. The charity had a strategic plan for 2016 – 2018 which included aims for developing the service as well as for the charity as a whole. The manager and director of residential services told us they kept themselves informed about local issues and changes in legislation and good practice by meeting with other providers and the local authority.

The provider asked people who used the service, their visitors and staff for their opinions about the service through annual satisfaction surveys. The most recent survey was undertaken in December 2015. People were asked about the building and environment, quality of the service and staff at the home. The results of the survey were positive and people had made comments about their experiences. Where people had identified an area they felt improvements were needed, the provider had created an action plan which outlined the action they would take.

The provider carried out a number of audits and checks on the service. These included an electronic record of how frequently call bells were answered, an analysis of accidents and incidents, audits of care plans and other records and a new audit they had introduced based on whether the service was safe, effective, responsive, caring and well-led. The provider had carried out a full audit on safety and had identified areas for improvement. They had started to take action to address these.

At the end of our inspection we gave feedback about our findings to the manager and director of residential services. They discussed how they would address some of the areas requiring improvement which we had identified.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not always provided care and treatment to service users which was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were always treated with dignity and respect. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way for service users because they had not always assessed the risk or taken all reasonable action to mitigate such risks. The registered person did not always ensure the safe and proper management of medicines. Regulation 12 (2)(a), (b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not maintain accurate, complete and contemporaneous records of the care and treatment provided to service users. Regulation 17(2)(c)