Shaw Healthcare Limited

Deerswood Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 July 2018 and was unannounced. 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.

Deerswood Lodge is situated in Crawley, West Sussex and is one of a group of homes owned by a national provider, Shaw Healthcare Limited. Deerswood Lodge is registered to accommodate up to 90 people across separate units, each of which have separate bedrooms with ensuite shower facilities, a communal dining room and lounge. There are also gardens for people to access and a hairdressing room. The home provides accommodation for older people and for those living with dementia. At the time of the inspection there were 80 people living at the home. The home had a registered manager. 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 2008 and associated Regulations about how the service is run.

Prior to the previous inspection on 26 and 28 July 2017, the registered manager had notified CQC about a death that had occurred. An incident that had occurred prior to the death indicated potential concerns about the management of risk in relation to falls. While we did not look at the specific circumstances of the incident at this inspection, we did look at associated risks. Whilst all other parties have completed their investigations, the CQC investigation remains at this stage, ongoing.

At the last inspection the home was rated as Requires Improvement. The provider was found to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Responsive and Well-led to at least good. A recommendation was made to improve the access to meaningful activities. There were concerns with regards to the sufficiency of staff, the maintenance of records and people's care records not always being reviewed to reflect their current needs. At this inspection people's access to meaningful activities and stimulation had improved. People and staff provided mixed feedback with regards to the staffing levels. Although no longer a breach of Regulation in relation to staffing, staffing levels were identified as an area in need of improvement. There is a continued concern regarding the maintenance of records and the reviewing of people's care. The provider and registered manager had failed to improve the service people received. This is the third consecutive time that the home has been rated as Requires Improvement.

At this inspection, we found medicines were not always stored safely. People were not always provided with dignified care when receiving their medicines. Some people had specific healthcare conditions and required their medicines at specific times. Records for one person showed that they had not been given their medicines in a timely manner to maintain their health or to support them to manage their condition. This was an area of concern.

Records to document people's care such as topical cream charts, fluid charts and repositioning charts were not always completed in their entirety. Reviews of people's care records had not always taken place following incidents. Staff were not always provided with the most up-to-date and current guidance to inform their practice. This was an area of concern.

People were asked their consent for day-to-day decisions that affected their care. Staff supported them in the least restrictive way possible and policies and procedures supported this practice. However, people were not always supported to have maximum choice and control of their lives. For people who had a health condition that had the potential to affect their capacity, their capacity had not been assessed in relation to specific decisions. Relevant people had not always been consulted to make decisions in people's best interests. This was an area of concern.

People told us that staff made them feel safe. People felt that staff were well-trained and knowledgeable to meet their needs and assure their safety. People and staff were aware of the importance of raising concerns about people's wellbeing and safety. People were protected from abuse and made aware of their right to complain.

People were protected from the spread of infection. External healthcare professionals ensured that people's heath was maintained. There was a coordinated approach to people's healthcare. People received good end of life care.

People had a positive dining experience. They told us that they were happy with the food and had access to drinks and snacks throughout the day and night. One person told us, "The food is good, freshly cooked".

Staff demonstrated respect. People's privacy and dignity were maintained and they were supported by staff in a sensitive and dignified way. Staff were kind, caring and compassionate. People told us that they felt well-cared for. They spoke fondly of the staff and person-centred practice was evident. One person told us, "I can't fault the girls. Most of them are extremely helpful and are there when you want them".

The environment provided spaces for people to enjoy time on their own or with others. There was a fun, lively and welcoming atmosphere. People had access to a varied range of stimulation. Activities, external events and entertainment was available for people to enjoy.

People and relatives were complimentary about the leadership and management of the home. They told us that the home was well-organised and that the registered manager listened and acted upon their ideas and suggestions. One person told us, "Yes, the place is run well".
Staff were appropriately supported and involved in decisions that affected their work. Partnership working with external organisations and healthcare professionals ensured that good practice was shared.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe.

Most people had access to medicines when they required them. There were safe systems in place to manage, store, administer and dispose of medicines. However, one person, with a specific healthcare condition, did not always receive their medicines in a timely way.

There was mixed feedback in relation to the sufficiency of staff. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Risks had been assessed to ensure people's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who might lack capacity. Although had not always worked in accordance with this.

Staff worked with external healthcare professionals to ensure that people received appropriate and coordinated care.

People were cared for by staff that had received training and had the skills to meet their needs.

Is the service caring?

Good

The home was caring.

People were supported by kind and caring staff who knew their preferences and needs well and who could offer both practical and emotional support.

People were treated with dignity and respect. They could make their feelings and needs known and were able to make decisions about their care and treatment.

People's privacy and dignity was maintained and their independence promoted.

Is the service responsive?

Good

The home was responsive.

People received responsive and personalised care to meet their needs.

People were involved in the development of care plans. These provided staff with personalised information about people's care.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the care people received.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Records to document the care that people received were not always completed or up-to-date to reflect people's current needs.

People, relatives and staff were positive about the leadership and management of the home.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home as well as day-to-day decisions that affected their care.

Deerswood Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 17 July 2018 and was unannounced. The inspection team consisted of three inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the previous inspection on 26 and 28 July 2017, the registered manager had notified CQC about a death that had occurred. An incident that had occurred prior to the death indicated potential concerns about the management of risk in relation to falls. While we did not look at the specific circumstances of the incident at this inspection, we did look at associated risks. Whilst all other parties have completed their investigations, the CQC investigation remains at this stage, ongoing.

Prior to this inspection we looked at information we held, as well as feedback we had received. We did not ask the provider to send us a Provider Information Return as the inspection was brought forward to enable us to follow-up on action taken since the last inspection. A PIR is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 19 people, seven relatives, one visitor, 11 members of staff, the deputy manager, the registered manager, the operations manager and the director of compliance and governance. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and electronic medicine administration records (MAR) for eight people, three staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed people in the communal lounges, their experiences during lunchtime and the administration of medicines. Following the inspection we asked the provider to send us some additional information about

people's medicines. The provider sent us this information in a timely manner.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 26 and 28 July 2017, the provider was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve. This was because there were concerns with regards to the sufficiency of staff. Records of call bell response times showed that people had sometimes had to wait for care. At this inspection, improvements had been made and the provider was no longer in breach of the Regulation.

People were provided with medicines to maintain their health. Medicines were administered by trained staff who had their competence regularly assessed. People told us that they were happy with the support provided. Staff were provided with clear and appropriate guidance to inform their practice. Most people had received medicines according to prescribing guidelines and when they required them. Most observations showed people were provided with their medicines in a respectful and appropriate way. One member of staff was observed administering a person's medicines not using a non-touch method. This was not in accordance with infection control practices or best practice guidance. The person indicated that they were experiencing pain. They were supported to have their transdermal pain patch changed whilst they were sitting at the dining room table having their meal with others. This did not promote dignified or respectful care as the person's shirt was pulled down over their shoulder to administer the transdermal patch.

Records of medicine temperature checks showed that the temperature in one of the medicine rooms had consistently exceeded the recommended temperature for a period of 15 days. There had been an exceptionally hot summer and some days the room had reached 30 degrees, this is 5 degrees over the recommended temperature required to safely store medicines. If medicines are not stored properly they may not work in the way that they are intended, and so pose a potential risk. Staff had recognised that the room was consistently too hot and had taken action, such as increasing the level of air conditioning in an attempt to cool the room. The room continued to be too hot and it was not until after 15 days of increased temperature that this was looked at by the maintenance team.

One person had experienced a high number of falls. Risk assessments assessed the level of risk and appropriate measures had been implemented to minimise the chances of reoccurrence. The person was able to make decisions in relation to their care and chose, at times, to mobilise without staff support. This had increased the risk of them falling. Although the provider had assessed the risk and had ensured that the person had the necessary equipment to ensure their safety, they had not ensured that the person had access to their medicines in a timely way. The person had Parkinson's disease and required medicine to manage their condition. Parkinson's UK recognise the importance of medicine optimisation for people living with Parkinson's disease. It states that getting Parkinson's medication on time is essential for symptom management. Guidance for the person's medicines, advised, 'Make sure you know exactly when to take your medication. Dose schedule and timings are important. Try to take the medicine at the same time each day'. Records for the person showed that they consistently had their Parkinson's medicines later than the time prescribed. There was a risk that because of this, the symptoms of the person's condition were not well-managed and placed them at potential risk of mobility issues.

Most risks to people's safety had been assessed and managed well. There had, however, been an incident whereby one person, who pursued a certain lifestyle choice, had not adhered to the provider's policy to ensure their own safety and that of others. A risk assessment had been completed when the person first moved into the home. This had identified the risk as moderate. There had been several separate incidents involving the person, however, staff had not reviewed the person's risk assessment after each incident. This meant that staff were not reviewing the person's care to ensure that the guidance provided to staff, in relation to risk, reflected the person's current needs. Staff were not provided with up-to-date information to enable them to minimise the on-going and increased risk.

The failure to assess, record and mitigate risks to people's health and safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the previous inspection on 26 and 28 July 2017, the registered manager had notified CQC about a death that had occurred. An incident that had occurred prior to the death indicated potential concerns about the management of risk in relation to falls. While we did not look at the specific circumstances of the incident at this inspection, we did look at associated risks. Whilst all other parties have completed their investigations, the CQC investigation remains at this stage, ongoing.

At this inspection the registered manager explained that changes had been implemented since the last inspection to ensure that people's needs were met by sufficient staffing. They explained that when assessing people's needs prior to them moving in, their needs were considered alongside the needs of other people at the home. This enabled staff to monitor the level of support people might need and ensure that they balanced this with the needs of others.

There continued to be mixed feedback in relation to staffing levels. Some people told us that, although staff were busy, there were enough staff to meet their needs. Other people told us that the home was often short-staffed. It was not evident if people were referring to the use of agency staff when making this statement, as records showed that there had been a consistent level of staffing to meet people's needs. Staff who worked on different units provided mixed feedback with regards to staffing levels. Some staff felt that there was sufficient staff and told us that they had time to sit and interact with people. Most staff we spoke to felt that staffing levels were not sufficient to meet people's social and emotional needs. One member of staff told us, "Sometimes there is not enough staff and I get stressed. I like to do my job perfectly and when we are short or have too many agency staff I can't do that. I don't always feel like I leave work knowing we have done our best for the residents. People's care needs are always met but we don't have time for anything else, to sit and chat and do the emotional side of our role which I feel is just as important".

There was no apparent impact of people's needs not being met. People's and staff's comments in relation to staffing levels were fed back to the registered manager and provider. The provider continued to recruit staff to increase their employed workforce, yet in the interim period had ensured that all shifts were covered sufficiently by using agency staff. Consideration was made to staff's skills and levels of experience. Less-experienced staff worked alongside the more-experienced to develop their skills and receive support and guidance to enable them to meet people's needs appropriately. The provider had been proactive in working with the local authority to keep staffing levels under review.

People consistently told us that they felt safe and secure. When people required assistance with their mobility, staff supported people safely and in accordance with their needs. Systems, processes and the practices of staff safeguarded people from abuse. Pre-employment checks ensured that staff employed were suitable to work in the health and social care sector. Staff understood their responsibilities to safeguard people from harm. Appropriate referrals had been made to the local authority when allegations

had been made. Advice and guidance provided by the local authority had been listened to and complied with.

People were protected from infection. Staff responsible for handing food had received appropriate food handling training. The home was clean and staff were provided with appropriate personal protective equipment to minimise the spread of infection. Staff disposed of waste appropriately to minimise cross-contamination.

Requires Improvement

Is the service effective?

Our findings

Although people told us that they were involved in day-to-day decisions that affected their care and that staff always gained their consent before offering support, we found that care and treatment was not always provided with people's consent.

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 make 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 MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider 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 had made appropriate DoLS applications. Those that had been authorised by the local authority sometimes had conditions associated to them. The registered manager and staff had worked in accordance with these to ensure that people's needs were met and they were not being deprived of their liberty unlawfully. There was an inconsistent understanding, however, when assessing people's capacity and making decisions about people's care. Records and observations of people's care, identified that some people had bed rails in place. Under the MCA Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails can be implemented for people's safety but are designed to restrict movement. Some people were living with conditions that had the potential to affect their decision-making abilities. The registered manager had not always ensured that these people's capacity was assessed in relation to consenting to the use of bed rails. Instead, a best interests decision had been made by a member of staff without firstly assessing the person's capacity to consent to their use or consulting and involving any relevant people involved in the person's care. This was an area of practice in need of improvement.

People told us they had access to sufficient quantities of food and drink. People had a pleasant and sociable dining experience. People could choose to eat their meals in the communal dining room or in their own rooms and told us that their wishes were respected. Drinks and snacks were available for people outside of meal times. People told us that they enjoyed the food. One person told us, "The food is good, freshly cooked". Another person told us, "The meals are pretty good. You choose your meals at the table and we always have enough liquids". Care plans identified people's cultural and ethical needs and support was adapted to ensure that people's beliefs were respected. Staff were mindful of encouraging people to eat. One member of staff was overheard asking another member of staff who was administering medicines to wait until the person had finished eating their meal. They told them, "Can you come back once they have finished. They are enjoying their lunch and it is important that they eat it".

People's needs were assessed prior to them moving into the home and on a regular basis. Care plans were specific and provided staff with advice and guidance about how to support people appropriately. People

received a coordinated approach to healthcare to ensure their healthcare needs were met. External healthcare professionals such as GPs, chiropodists, opticians and dentists were accessed to support people to maintain their health and well-being. People told us that they had faith in staff's abilities to recognise when they were not well. Regular routine visits from GPs and healthcare professionals enabled people to discuss their health. One person told us, "The GP comes in every week and will come in if you are unwell".

Staff had sufficient skills, knowledge and experience to deliver effective care. People and relatives were complimentary about staff's abilities. They told us that they were skilled and experienced. One person told us, "The older staff are quite efficient". Another person told us, "Staff do seem well-trained". Staff received a comprehensive induction and had access to on-going learning and development to ensure that they could meet people's needs. Links were maintained with the local authority, external healthcare professionals and local colleges to promote and share best practice.

People's needs were met by the design, layout and adaptation of the home. Consideration had been made to the aesthetics of the building as well as the practicalities. People had their own rooms that they could use if they wanted to have their own space. People could choose to enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather. People were supported to independently mobilise around the home and technology, such as call bells and sensor beams, were available for people to use if they required assistance from staff.

Good

Is the service caring?

Our findings

People and relatives consistently told us that staff were caring, kind and compassionate. Comments from people included, "The staff are lovely", "The people who work here are kind", "The staff do ask how we are, they are nice and very kind" and "The carers make the place what it is, they will do anything for you". Relatives were equally as positive, a relative told us, "I can't praise them highly enough". When people and relatives were asked why they thought staff were caring, one person told us, "I can't fault the girls, most of them are extremely helpful and are there when you want them". A relative told us, "I feel it's so homely, staff are friendly".

People were cared for in a sensitive and thoughtful way. People were treated with kindness and staff anticipated people's needs. Most staff took time to interact with people and were aware of signs that indicated people might be becoming anxious. One person was showing signs of apparent anxiety. They were concerned and worried of what was expected of them and what they needed to do. Staff took time to reassure the person, they spoke with them about what they would like to do and engaged them in an activity. This distracted the person and they were observed to be more settled and were smiling and interacting with staff and other people. Another person was confused as to the reasons why they were at the home. A member of staff took time to acknowledge these feelings. They demonstrated empathy and understanding and reassured the person. They explained that it was normal to feel apprehensive and worried as it was a big change moving into a care home. They took time to listen to the person and asked them if they would like them to remind them where their room was so that the person could see familiar things around them. The person was reassured by this and thanked the member of staff.

People and their relatives could express their needs and wishes. People were involved in their care. A relative told us, "They do involve us about my relative's care and they ring when they need to tell us anything". Information about people's life history, their hobbies, interests and preferences had been gathered and recorded in people's care plans. Staff told us that this information was valuable as it enabled them to gain an insight into people's lives before they moved into the home. People and their relatives, were encouraged and able to provide feedback about their care and the running of the home. Regular resident and relative meetings, as well as surveys, enabled people and their relatives to make suggestions and have an input into their care. People were made aware of advocacy services when they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

Consideration was made with regards to shared living and the difficulties that this could sometimes pose. The registered manager told us that people's needs and support requirements were considered prior to them moving into the home. They explained that once an initial assessment of people's needs had taken place, these were considered alongside the needs of others already residing in the home. It was felt that this helped to ensure that people would be compatible and content living together. At times, when staff were aware of potential compatibility issues between people, measures had been taken to ensure that people were appropriately supported. Care plans and assessments detailed people's needs and staff worked in accordance with these to ensure that altercations between people were minimised and diffused. A relative

told us, "I can't fault the staff. They have to deal with difficult people and they are very good at it".

People were respected and their privacy and dignity was maintained. A relative told us, "They do give my relative the respect and dignity they deserve". Staff explained their actions and gained people's consent before offering support. People were fully involved in day-to-day decisions that affected their care. People told us that they could choose the gender of the staff that supported them and confirmed that this was listened to and respected. One person told us, "Staff do seem respectful. I don't mind who looks after me, I am sure they would respect my wish to have ladies look after me". Staff supported people with discretion and consideration. They were sensitive when assisting people with their personal care needs. People's diversity and individuality was recognised and respected. People could wear clothes of their choice, they wore jewellery or had their nails painted in their preferred colour. One member of staff told us, "I like to treat people as a person not a condition. It is about knowing people and offering the right kind of support when they need it, emotional support and encouragement to try new things".

People's privacy, with regards to information that was held about them, was maintained. Records were stored in locked cabinets and offices and conversations about people's care were held in private rooms.

People were encouraged to remain as independent as their abilities allowed. One person told us, "In a way I do feel independent". Some people accessed the local community and shops independently and told us how much they valued this sense of freedom. People were encouraged and able to continue to do as much as they could for themselves. Staff were mindful of the importance of encouraging independence and the retaining of skills. For example, some people were provided with mobility equipment or adapted cups and cutlery to enable them to remain as independent as possible when undertaking certain tasks. One person told us that they enjoyed laying the tables for meals and another was overheard informing staff that they were going to their room to put away their clean washing.

People could maintain relationships with those that were important to them. Relatives told us that they were made to feel welcome and could visit at any time. A relative told us, "They make me feel I am part of a family. I cannot fault them". Friendships had developed between people as well as with staff. One person told us how much they enjoyed sharing lunch with another person who lived on another unit. People were actively encouraged to participate in group activities and shared interests to improve and maintain their social needs. People also had access to telephones to enable them to stay in touch with their family and friends if they wished.

Good

Is the service responsive?

Our findings

At the previous inspection on 26 and 28 July 2017, we recommended that the provider sought advice and guidance from a reputable source with regards to the provision of meaningful activities and interaction for all people. At this inspection, it was apparent that improvements had been made. People and relatives told us that there were sufficient activities and stimulation to occupy their time and our observations further confirmed this.

People's participation in activities was informed, in part, by information that had been gathered about people's interests and hobbies. This information formed part of people's care plans and provided staff with guidance about people's likes and dislikes. One member of staff told us, "One person likes the football so during the World cup I got up-to-date with the scores so we could chat about it". All people had access to activities or stimulation to meet their social needs. Dedicated activities staff ensured that they and other staff, took time to interact with people. They ensured that when people could not participate in planned, group activities, they were provided with an activity or interaction that best met their needs and records and people confirmed this. Observations showed one member of staff took time to sit with two people who were living with dementia. They engaged in a cross-word puzzle. The member of staff demonstrated patience and took time to encourage people to think about the questions. They used the activity as an opportunity to encourage reminiscence and a conversation about a person's life ensued. Other people who were living with dementia were encouraged to enjoy a sedate game of rolling the ball. People appeared to enjoy this and interacted with each other as well as with staff. There was a varied range of planned group activities, entertainment and events that people could choose to partake in. These included musical entertainers and visits to places of interest. Information about people's hobbies had been used to plan activities that were of interest to people. These included the introduction of a photography club were people had taken photographs and were supported to use editing software on a computer to edit their photographs.

People were encouraged and able to maintain relationships and links with the local community. People were supported to have regular trips outside of the home. Some people had enjoyed a visit to a local coffee shop and told us about the tea and cakes that they had enjoyed. People's right not to participate in activities was respected by staff. People told us that they sometimes liked to watch television, read newspapers or have a sleep. One person told us, "The activities and entertainment are good. There is enough choice. The activities coordinators do try and involve all residents and try to plan a programme to suit all. They take us out for a walk and for a cup of tea and even to the theatre".

People's right to have information provided in an accessible manner was respected. People's communication needs had been identified and met. People's care plans contained information on the most appropriate way of communicating with them. People were cared for and communicated with in a way that was specific to them. Staff were patient and adapted their approach to meet people's needs. Information for people and their relatives, if required, could be created in such a way so as to meet their needs, for example, in accessible formats to help them understand the care available to them.

People's care was centred around their needs and preferences. People and their relatives told us that they

were involved and kept informed and updated about any changes in people's care. One person told us, "They do talk to us about our care". A relative told us, We are able to discuss daily routines and longer-term care plans with carers and management alike". People's care plans were specific to them as individuals. People's diversity was acknowledged and respected and care was adapted to meet people's needs and preferences. Regular reviews of people's care ensured that the care provided was consistent with people's expressed wishes.

People had access to technology to summon assistance from staff. Call bells and sensor beams, which sounded an alarm when people mobilised, alerted staff to people's need for assistance. People told us and our observations confirmed, that when people summoned assistance, staff responded promptly. One person told us, "I fell out of bed and they came quite quickly". A relative told us, "My relative falls over constantly. They have a pressure mat and when they fall over, the staff all come running".

People were aware of the complaints procedure and were supported by staff if they needed assistance to make their feelings known. Complaints that had been raised had been dealt with appropriately and in accordance with the provider's policy. People and relatives told us that the providers and the management team were responsive to any concerns raised.

People were provided with good end of life care. People and their relatives, if they wished, had been able to plan for the end of their lives. Records showed that people's expressed wishes and health needs had been met and people had passed away in accordance with their wishes. There were links with local hospices and healthcare professionals to ensure staff were provided with appropriate advice and guidance. Measures had been taken to ensure that the necessary equipment and medicines were available in anticipation of people's health deteriorating. People's comfort was maintained. One member of staff told us about how they had cared for a person during the last stages of their life. They told us, "They weren't left alone so they didn't pass away alone. Their hearing was the last sense they had, so I kept speaking to them and could see this was comforting in their body language. It was very respectful and dignified as we made them comfortable".

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 26 and 28 July 2017, the provider was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question to at least good. This was because there were concerns with regards to the maintenance of records to document the care people had received. This related to people's food and fluid records. Some people's records had not been completed. Those that had been, had not had sufficient oversight to ensure that people were receiving sufficient fluids throughout the day. People who had lost weight had not had their weight loss documented in accordance with the provider's policy. Reviews of people's care, to ensure that the guidance provided to staff was current, had not always been completed. At this inspection, the provider continued to be in breach of the Regulation. Similar themes with regards to the monitoring of people's care and the maintenance of records were areas of concern. This is the third consecutive time that the home has been rated as 'Requires Improvement'.

Deerswood Lodge is one of a group of services owned by a national provider, Shaw Healthcare Limited. The management team had experience within the health and social care sector. There was a management hierarchy which enabled staff to be supported and supervised by team leaders who worked alongside them to meet people's needs. In addition, there were two unit managers and the registered manager. An operations manager also regularly visited the home to conduct quality assurance audits and to offer support. The lack of oversight and action taken to ensure that areas previously identified as requiring improvement within the provider's audits and at the last inspection, was a concern. Complete and accurate records were not maintained to document people's care.

People's risk of malnutrition was assessed on an on-going basis. One person had experienced unintentional and unplanned weight loss over a six-month period. Staff recognised that this needed to be monitored and the person had been weighed the following month. Staff had not recorded this in the person's care records and had instead recorded it in their own notebook. The person had lost 5.1 kilograms within one month meaning an 8.7 kilograms loss in seven months. The member of staff had alerted the person's GP who had agreed that they could have their nutritional supplements increased. The member of staff explained that the person disliked the supplements and would often refuse them. They explained that they were going to try to alter the supplements to make them more palatable. When the member of staff was asked if the person's food was fortified to increase their calorie intake, they explained that it was. They also explained that the person would be weighed each week to monitor their weight more closely, as this was in accordance with the provider' policy. A member of staff confirmed that the person had not been weighed since the significant weight loss had been identified more than a week previously. When discussing the person's change in needs and the need to increase the calorific value of their food, with the person who prepared the meals, they were unaware of this requirement. They explained that they did not fortify any person's meals. As the member of staff had recorded the person's recent weight loss in their own notebook, other staff had not been made aware of this. It was not evident within records or through staff's awareness that the person had been provided with fortified food to increase their calorie intake.

People had their skin integrity assessed. Records for two people showed that they had been assessed as being at high risk of skin breakdown. Staff were provided with clear guidance informing them of the preventative measures in place to reduce the risk. This involved pressure relieving equipment and regular repositioning. Records to document the frequency of repositioning showed that the people had not always been assisted to reposition as frequently as was advised in their care plans.

The lack of documentation raised concerns regarding the care people received. The provider could not always evidence if people had received the necessary care or if staff had failed to accurately record their actions in people's records. This was of significant importance due to the use of agency staff and the increased need to ensure that there was clear, accurate and up-to-date information for staff, who may be unfamiliar with people's needs. The provider had not ensured that there was sufficient oversight of documentation to ensure that there were accurate, complete and contemporaneous records for each person.

There was a comprehensive quality assurance system to monitor quality and identify areas for improvement. These were conducted by the registered manager, the operations manager and the provider's quality team. The provider had a robust quality assurance system which had identified some areas for improvement. The recording of people's topical cream application, the totalling of fluid charts and the reviewing of risk assessments had all been identified within two consecutive quality audits. It was not evident what action had been taken to improve this as these areas of practice remained a concern at this inspection. The quality assurance processes had failed to identify the lack of understanding and practical implementation of the MCA.

The registered manager and provider had failed to take sufficient action to ensure that they assessed, monitored and improved the quality and safety of the service provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's values of 'Wellness, Happiness and Kindness', were shared by the management team and staff. They worked hard to ensure that they were embedded in their practice. One person told us, "It's a comfortable place to live, I am very safe and content living here. I would recommend it". Comments from relatives included, "We as a family feel very content and are happy they are well looked after. Overall this is a great place and we'd recommend it" and "Generally I'm okay with things here and it seems to be run quite well". There was an open and transparent culture. People and their relatives told us that they were kept informed about people's care and the running of the home. Regular meetings provided people and their relatives with updated information and informed them of events and activities that were to be held at the home. Regular surveys enabled people and their relatives to provide feedback and share their views. People told us that their feedback was listened to and acted upon. One person told us, "They reacted to my suggestion of reducing meal sizes and it's working well".

There was consistent, complimentary feedback about the management of the home by all. One person told us, "I do get along with the management, they are definitely approachable if I have a problem". A relative told us, "The manager and all the staff are brilliant, approachable and responsive". Staff were equally as positive, they told us that they felt valued and appreciated, that they could share their ideas and suggestions. Comments from staff included, "I feel valued by the manager they are open and really care. There is a serious level of management but they are also caring and compassionate. They are very approachable", "I feel very valued, I know my hard work is acknowledged and respected by team leaders and managers. They say thank you and have an open door. They listen to me and I can offer my opinions on things happening at the home" and "I feel well-supported by management, if we have a problem they are always available. It's the best place I have ever worked, everyone is calm and they don't panic. Good work

life balance".

The provider and registered manager were aware of their responsibilities to comply with 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. There was good partnership working to ensure staff learned from other sources of expertise and people received coordinated care. This enabled the sharing of good practice.

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 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.

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