East Anglia Care Homes Limited

Sutherlands Nursing Home

Inspection report

136 Norwich Road
Wymondham
Norfolk
NR18 0SX
Tel: 01953 604200
Website: www.eachltd.co.uk

Date of inspection visit: 26 and 28 January 2015
Date of publication: 08/05/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 26 and 28 January 2015 and was unannounced. It was carried out by two inspectors.

Sutherlands Nursing Home is a care home providing nursing care and support for up to 52 older people, some of whom may be living with cognitive impairments such as dementia.

The provider is required to have a registered manager at the service. 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.

However, there had not been a registered manager at the home since May 2014. The previous manager, who had not been registered, left the service in November 2014. The provider was recruiting for a new manager who

Summary of findings

would apply for registration. At the time of this inspection a previous registered manager of the service, referred to in this report as a supporting manager, had stepped in to manage the service three days a week.

There were not enough staff to ensure people's needs were met. People who required support with eating and drinking received a poor standard of assistance. These concerns represented a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's quality assurance systems were not being effectively or regularly utilised to determine the standard of service people received or where improvements could be made. Where people's views had been sought through a questionnaire, no further work had been done on the information received to help drive improvement. There was no formal mechanism to obtain or act upon the views of staff to in relation to the care and treatment people received. These concerns represented a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People felt safe living in the home. People's relatives were satisfied that their relatives were supported safely. Staff knew about keeping people safe from abuse and were aware of safeguarding procedures and what actions they would need to take if they had any concerns.

People enjoyed their meals and were given choices in what to eat or drink. The food looked and smelled appetising. However, people requiring support with their meals did not always receive this in an effective manner.

The nursing care people received in the home was good. People were also supported with their health by a range of visiting health professionals.

People's consent was sought before assistance was provided. If people were unable to give consent staff ensured that they provided care that was in the person's best interest. The supporting manager was aware of the circumstances under which people could be deemed as being deprived of their liberty. They were taking action to comply with the provisions of the Deprivation of Liberty Safeguards (DoLS).

Staff were mainly caring and attentive to people's needs, identifying when people required support without the person needing to ask. However, we found instances where this wasn't always the case. Assistance was provided discreetly when necessary.

People's needs were assessed and their care was planned to ensure their needs could be met. Staff knew the people they were supporting and told us about people's likes, dislikes, their habits and how they needed to be supported to help maintain their safety and welfare. However, sometimes their preferences were not taken into account in the way that their care was organised and provided and sometimes care wasn't adequately organised to ensure people's safety and welfare.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People were not receiving care that met their needs because insufficient staff were available to support them.

Staff understood how to keep people safe, but did not know how to raise concerns outside of the provider's organisation if necessary.

People received medicines prescribed for them in a timely and safe manner.

Is the service effective?

Requires improvement

The service was not consistently effective.

Arrangements to support people who needed assistance to eat and drink needed improvement.

People received competent support with their health from nursing staff and other health care professionals when necessary.

Staff understood about consent and respected decisions people made.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff were mainly, but not always, observant. Most staff noticed when people needed their assistance and provided this discretely when required.

Most people and relatives spoke positively about the care provided by staff.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's needs were assessed and care and support was planned. However people's needs were not always met or delivered in a timely manner.

Complaints had been dealt with in a timely way.

Is the service well-led?

Requires improvement

The service was not consistently well led.

There was no registered manager in post. Several staff, including managers, had left in recent months and this had affected the stability of the staff team and standard of service people received.

Checks that were in place to monitor the service people received had not routinely been carried out in recent months.

Where areas for improvement had been identified, plans had not been made to implement the necessary changes.

Sutherlands Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 26 and 28 January 2015 and was unannounced. It was carried out by two inspectors.

Prior to this inspection we looked at the notifications sent to us by the provider. These are notifications of events that the provider is required to send us by law.

During our inspection we spent time observing how staff interacted with people who lived in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who lived at the home, five visiting relatives, seven care or nursing staff and kitchen staff. We also spoke with a previous registered manager of the home who was supporting the service and the provider.

We looked at eleven people's care records, three recruitment files, staff training records and various records relating to management of the service.

Requires improvement

Is the service safe?

Our findings

Prior to this inspection we had received concerns about staffing levels in the home. During the inspection people told us there were not enough staff. For example, people told us, "They need more staff." and that, "No-one has time to chat with me these days." Another person told us, "I'm never washed until gone 11.30 am." We checked their records and saw that on five of the last eight days they had not been assisted to have a wash before midday. Records for another person, who was unable to communicate with us, showed that on four of the last eight days they too had not been assisted to have a wash until after midday. A staff member told us that there was not enough time to assist everyone with personal care in time for lunch and that sometimes they hadn't been able to ensure everyone had finished lunch by 2 pm. A relative told us they were unhappy that staff had only had the time to assist their family member with a bath once in a two week period.

At the time of our inspection 37 people were living in the home, all of whom we were told required nursing care. The premises comprised of four wings with staff designated to each wing. The supporting manager told us that they needed eight care staff on a morning shift and six on the afternoon/late shift. However, due to several care staff members leaving in recent months, shifts often had seven care staff in the mornings and five on the afternoon/late shift. Staffing rotas we viewed covering the period 22 December 2014 to 25 January 2015 showed that on several occasions care staff numbers were below these reduced levels. Two care staff members were required on the Minton wing which supported people living with dementia. This left few care staff on the afternoon shift to look after the remaining 30 people downstairs, many of whom required two members of staff to assist them with personal care.

The rotas showed that the service operated with two nurses during the day and one at night. However we found that the training officer, who was not a qualified nurse, was shown on the nursing rota for three day shifts a week. This meant that on these shifts there was one nurse on duty to meet the nursing needs of 37 people. Some nursing staff we spoke with were unhappy with this arrangement. They told us they felt under considerable pressure on these shifts and felt that people's safety was at risk.

The operations manager had needed to cover two night shifts as the nurse on duty and the supporting manager had also covered a nursing night shift. The supporting manager and provider told us they were trying to recruit nursing staff, but that this was proving problematic.

We were unable to establish how staffing requirements were determined by the service. In November 2014 the manager at the time sent us documents they told us were used to evaluate what care people required. However, these were routine assessments of people's care. Earlier in January 2015 the operations manager had informed us that they were revising the way people's dependency was assessed to more effectively determine what staffing numbers were required. However, they were currently off work so we were unable to explore this further.

We visited the Minton wing, which supported people living with dementia, and found that no staff were present. One person was trying to get out of their chair and was at risk of falling. We persuaded them to sit down whilst we found some staff to assist them. Another person was putting tissues into a beaker and trying to drink from it. Shortly afterwards two staff came into the room. They were returning someone to the lounge who needed two staff to assist them with their care and had not been gone long. However, leaving people alone in this lounge, even for a short period of time, was exposing them to unnecessary risk.

These issues represented a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in the home. Relatives we spoke with told us they had no concerns about their family member's safety and that they were cared for in a safe manner. Staff told us about different kinds of abuse and what action they would take if they suspected abuse had occurred. They all stated they had not needed to raise any concerns. All staff had received training in safeguarding. There was information available about safeguarding for visitors to the home in the reception area.

Requires improvement

Is the service safe?

However, we were concerned that three staff we spoke with were unfamiliar with whistleblowing arrangements. They did not know that they could report concerns about the service outside of the provider's organisation if necessary. Neither did they know who they could report concerns to.

On the Minton wing we observed a staff member sat at a lounge table completing paper work with their back to the people in room. People in this wing sometimes presented challenging behaviour. When we entered the lounge we saw one person crawling across the floor towards the staff member, who hadn't seen them. This person was unable to mobilise safely without assistance but had got out of their chair unnoticed. This person's safety had been compromised.

Risks to people's safety had been assessed. These were completed on an individual basis and detailed what action was necessary to remove or reduce the risk. Staff we spoke with were familiar with the people they were supporting and aware of how they needed to be cared for to ensure their safety. For example, staff told us how two people needed to be supported with their mobility and the different requirements each person had. This information corresponded with the information from each person's mobility risk assessment. However, our observations of the Minton wing meant we could not be sure that appropriate support was always provided to ensure people's safety.

Effective recruitment processes were in place. We reviewed the records of recently recruited staff. Staff were employed only when the necessary checks had been completed satisfactorily on their backgrounds. We checked records of nursing staff and found that the provider had ensured that all nursing staff remained registered with the Nursing and Midwifery Council (NMC) and were fit to practice.

The arrangements in place for the management of medicines were safe. Medicines were securely stored. Nursing staff followed relevant guidance. For example, we saw that when one person had a seizure that nursing staff followed the person's seizure care plan and emergency procedures to help ensure the person's recovery and welfare. The provider had an up to date medicines policy and procedure in place.

Detailed records were kept of when medicines were received, administered and disposed of. These records showed that people received the medicines that had been prescribed for them. We observed one nurse during a medicines round. This was done effectively and people received their medicines in a timely and safe manner.

Requires improvement

Is the service effective?

Our findings

People told us the food was good. One person told us, "The food is very nice. There's always something hot for tea." Another person said, "Lunch was good today. The rice pudding and jam was lovely." People had drinks available to them whether they were in their room or in a communal area. One person who required full assistance to eat and drink told us, "Staff are good at helping me to drink. I'm never thirsty."

However, we found that people were not always given the support they required to drink in a timely manner. One person had been brought a hot drink by a kitchen staff member but no care staff member had come along afterwards to assist them to drink it whilst it was still hot. We saw from minutes of a staff meeting that this had been previously been identified as an issue.

We observed a lunch time in one of the dining areas. The table was nicely set with napkins and a cruet set. A hot food trolley stood by the wall from which staff served people in the dining area and those who took meals in their rooms nearby. People in the dining area had a choice of three drinks. Five people were having their lunch here. One person needed full assistance from staff to eat their lunch. The staff member assisting this person with their lunch got up three times to assist other staff or to serve other people at the table. Lunchtime was a poor experience for this person.

Nutritional care plans were in place for people. Their nutritional needs were reviewed on a regular basis. Where staff were concerned that people had lost weight they had been referred for specialist advice. Food and drink consumed by people deemed at risk of malnutrition was recorded and reviewed so that further action could be taken if necessary to help ensure people's nutritional needs were met.

People or their relatives were positive about the standard of nursing care received. Relatives told us they were kept advised of any changes in their family member's health. "I'm confident my Dad is getting good nursing care" one relative told us. Another person said, "The nurses know what they're doing here."

The service provided good pressure area care. We reviewed records of people in the home who had pressure ulcers. We found care plans in place for each person and saw records to show that dressings had been changed in accordance with their care plans and wounds re-evaluated as necessary. People cared for in bed were repositioned as necessary. One person's care records included pictures and a clear explanation of how to position the person comfortably in their wheelchair to prevent skin friction. We saw this person had been positioned as required.

People's care had been planned to take account of guidance from specialist health professionals, for example neurologists. We saw that a range of health professionals assisted the home's nurses to provide the health care people needed. These included GPs, dieticians, speech and language therapists, continence advisors, renal nurses and those specialising in the care of older people.

Training records showed that staff undertook annual training. Many people living in the home were living with dementia, some exhibited challenging behaviour at times. There was training available for both dementia and challenging behaviour, but few staff had completed it. The supporting manager told us that they also needed more in depth training on mental capacity and end of life care which was being arranged. Newer staff told us about their induction, that this was a combination of classroom training and shadowing experienced staff. Care staff told us that they referred to the training officer for advice or the nurse on duty. They told us there was always someone available if they needed guidance. The provider supported staff to start or progress care qualifications.

Care and nursing staff had received regular supervisions and appraisals until December 2014 when the manager left. Staff told us supervisions were helpful and supportive and gave them a chance to discuss how they provided care to people and whether there were more effective ways to do this. Nine housekeeping or kitchen staff had not received any supervision since June 2014. The supporting manager was aware that this needed rectifying, but the home's staffing situation at the time of this inspection was making this difficult as the training officer, who assisted the manager to carry out supervisions, was often required to assist care staff.

People's consent was sought before any support was provided. We observed one carer asking a person who was in a lounge if it was okay to go into their room to fetch them some tissues. Where people were unable to consent we saw that day to day decisions were made in people's best interests. We observed a staff member showing one person

Requires improvement

Is the service effective?

a clothes protector and although the person was unable to express consent the staff member talked them through what they were doing in an easy, relaxed manner. The person was content to have the clothes protector put on.

CQC monitors the application of the Mental Capacity Act 2005 and the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The DoLS provide a legal framework around deprivation of liberty to ensure that people do not have their freedoms restricted without good cause or proper assessment. The supporting manager was aware of a court decision which widened the definition of a deprivation of liberty. They had been in contact with the local authority to which applications needed to be submitted and were in the process of making applications as required.

Requires improvement

Is the service caring?

Our findings

Whilst we received positive reports about how caring the service was, we also received views and observed care that didn't support that the service was consistently caring. Some people had to wait considerable lengths of time to be assisted with personal care which did not support their dignity. People didn't always receive the support they needed to eat and drink. This was not indicative of a service with a consistently caring approach to supporting people or meeting their needs.

People we spoke with told us the staff were caring. One person told us, "There's nothing to grumble about, the staff are very good." Another person said, "They're always polite." A relative described the way their family member was cared for was with "…warmth and tenderness."

Staff took time to explain things so people knew what was happening and supported them to do things at their own pace so they were not rushed. We observed staff using a hoist to transfer one person between a wheelchair and lounge chair. Staff reassured the person throughout the process. The majority of the time staff were observant and responded quickly to ensure people's comfort was maintained. One person had put their glasses on upside down which was spotted and discretely rectified by a staff member. Another person was offered a cushion when staff saw they were repeatedly trying to adjust their position.

People who were able to participate in planning their care told us their views about how their support was provided were sought by staff on an ongoing basis. One person said, "They want to make sure I'm happy about the way things are done." Where people were unable to participate their relatives or representatives were involved. We spoke with the family of one person who had recently been admitted to the home. They felt that staff welcomed their input, queries and suggestions to help provide a good standard of care for their family member. Another relative told us how when their family member had experienced a period of poor health that communication from staff had been good. The relative had been kept well informed of their family member's progress and what support they were receiving.

People's clothes were clean and well ironed. People looked cared for and cared about. Their rooms were clean and tidy. This showed that housekeeping staff played their part in supporting people in a way which promoted their dignity.

People had the privacy they needed when friends and family visited. They could visit in the person's room, but there were several areas within the home with comfortable chairs in groups which still offered a good degree of privacy. We spoke with one family group in one lounge who told us that they found it nicer to spend time with their family member in a lounge environment because "…that what it was like when [their family member] was at home."

Requires improvement

Is the service responsive?

Our findings

During our inspection we saw the support care staff gave to people matched the information in their care records. For example, we saw how care staff supported people to move around the home using the specialist equipment detailed in their records. This demonstrated that these people were receiving care responsive to their individual needs. However, some people's needs were not being met in a responsive way. For example, people were not given a choice as to when they received personal care. Care was sometimes delivered in a task orientated way that detracted from people having as much choice and control as possible in how they were supported.

One person said, "I can sort myself out most days, but they help me with a shower twice a week." Another person told us, "If I need something they'll do their best to get it for me." Staff knew the people they cared for and told us about people's individual preferences. For example, they knew who preferred specific drinks. One staff member told us the signs they used to identify that one person was unhappy and how to tell from changes in people's behaviours that they might not be feeling well.

People were able to have their room how they wanted it. We saw people had a range of different styles of furnishings in their rooms, and people had brought things from their previous residence to make their room homely. One person had kept budgies and had been able to bring these with them when they moved in. The home had arranged the support required to keep the pets looked after. This had helped to make the person feel welcome in their new home and showed how the service helped people maintain their interests.

The service's new activities co-ordinator had just started working at the home. One person told us how much they had enjoyed the conversations they had had with the new staff member about what questions could be asked at a quiz that was being planned. They said, "Those chats made my day." Whilst there had been few organised activities since the previous staff member had left in the autumn of 2014, now the vacancy had been filled people were looking forward to improved social interaction.

The manager completed comprehensive pre-assessments in respect of each person before they moved in. Information was obtained from the person, their representatives and health professionals to ensure the person's needs could be met. Once the person had moved in their care was then planned in more detail, taking into account people's specific requirements and preferences and upcoming health appointments. People's care was then kept under monthly review.

The provider's complaints policy and procedures were available for visitors in a folder in the reception area of the home. A copy was also available in the service user guide which was kept in people's rooms. People told us they would make a complaint if they felt it necessary.

The service responded to complaints promptly. We viewed how the four complaints received over the previous year had been dealt with. We saw that the then manager had investigated the complaints and they had made contact with the complainants to discuss matters. However, we only saw two written responses. We spoke with a staff member who told us the action they took to ensure there would be no repeat of events that led to the complaint.

Requires improvement

Is the service well-led?

Our findings

Systems were in place to monitor the quality of the service provided to people. However, these checks had slipped in recent months. As a result the provider could not be sure that people benefitted from safe, quality care, treatment and support. The previous manager had undertaken unannounced night time visits in July and August 2014. None had subsequently been carried out which meant that the provider could not be assured that people continued to receive appropriate support during the night. The operational manager had carried out monthly 'provider visits' in November and December 2014, but no action plans had been drawn up to address areas requiring improvement that had been identified. Other audits had last been carried out some time ago. For example, the supporting manager could only find a medication audit carried out in July 2014.

Staff told us there was no staff questionnaire to obtain their views about the service, how it was managed or where they felt improvements could be made.

These issues represented a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were given the results from a questionnaire issued to people living in the home and their relatives during May 2014. The options for answers were 'good', 'satisfactory', 'poor', 'not applicable' or 'no comment'. Only 57% of respondents rated the overall service provided 'good'. This meant that there was scope for improvement. We asked if an action plan had been made to determine what improvements could be made as a result of the questionnaire. The supporting manager wasn't sure whether there was one and was unable to find one on the day of our inspection. The lack of action in response to the results of this questionnaire was not indicative of a service with an ethos of continuous improvement.

Few of the staff we spoke with were willing to give us their views on how the home was run. One staff member told us, "Too many people have been shouted at." But they refused to elaborate. However, staff were happy to tell us about their training, about people they supported and how they worked on a day to day basis. Although on the days of our inspection we observed good communication between nursing and care staff, we received mixed views about this relationship from some care staff. Some told us how nurses helped out by assisting people with meals and were approachable. Others told us that they were reluctant to approach nurses because they were so busy and looked more to the training officer for support.

The service was operating without a full time registered manager in place. The operational manager was also absent from the service at the time of this inspection. A previous registered manager, referred to in this report as a supporting manager, had stepped in to manage the service three days a week. They had only been supporting the service for a week prior to this inspection. In recent months several staff, including nurses had left. The provider was aware of the home's staffing issues and was recruiting.

People living in the home and relatives we spoke with were unclear about the current management arrangements for the home. One person said, "I'm not sure what's happening now." A relative told us if they had a complaint they would tell someone, but they weren't sure who to tell given the changes that had taken place. The last resident and relatives meeting had been held in October 2014, but had been poorly attended.

The atmosphere between staff, people living in the home and visitors was open and receptive to discussion. Communication between the management team and staff needed improvement. Without exception staff welcomed the supporting manager who was managing the service three days a week. They had considerable respect for them, but they were clearly wary about raising concerns or discussing matters with the wider management team.

The service had been holding regular internal meetings to discuss matters and inform staff about upcoming known changes. Management meetings had been held up to and including November 2014. The training officer had convened a carers meeting in early January 2015 to help support the staff and discuss matters. One staff member told us that this meeting had helped them feel involved and motivated through a difficult period for the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing **People's needs were not being met as there were insufficient numbers of staff deployed to support them. Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The quality of the service was not being effectively monitored. Effective systems were not in place to obtain and act upon the views of staff. Regulation 17(2)(a)(e)(f)**