Hydefall Limited

Sutton Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 and 12 December 2016 and was unannounced. The last inspection of Sutton Court Care Centre was carried on 12 and 16 May 2016 when we rated the service 'Requires Improvement' overall. This was because we found the provider continued to fail to operate effective governance systems. Specifically, the provider's arrangements to monitor the quality and safety of the care and support people received at the home had failed to identify that up to date moving and handling and falls risk assessments were not always in place. The meant people might be at risk of receiving unsafe care and/or being harmed. We also identified two new issues in respect of staff not receiving up to date moving and handling training and staff turnover in the past year being high. This meant staff might not have the right knowledge, skills and experience to meet the needs of people they were supporting.

We took enforcement action against the provider by issuing Warning and Requirement Notices and told them to take action to make improvements.

Since our last inspection the provider had made some improvements, most notably to the ways in which they monitored the quality and safety of the care and support people received at the home. This included appropriately maintaining moving and handling and falls risk management plans and ensuring moving and handling training was kept up to date for staff.

Sutton Court Care Centre is a residential care home that can provide nursing and personal care for up to 63 older people. This four storey purpose built care home has four distinct units located on each floor of the building, including a specialist 22 bedded dementia unit on the first floor. At the time of our inspection there were 62 people residing at the home, of whom approximately half were living with dementia and/or had complex health care needs.

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 2008 and associated Regulations about how the service is run.

At this inspection we found the provider did not ensure staff treated people with respect and dignity at all times. Although people told us they were happy living at the home and we observed most of the interaction between staff and people using the service were characterised by dignity and compassion, we found some staff did not always engage with people in a caring and respectful way. For example, on one occasion we witnessed a member of staff use inappropriate language when talking to a person who lived at the home. We also found half of the 12 members of staff we observed supporting people to eat their lunchtime meal did not always engage well with the person they were assisting. For example, very little attempt was made by these staff to make eye contact, explain what was on people's plates or speak to the person they were supporting to eat and drink.

This was a breach of the Health and Social Care (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.

There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse. The provider assessed and managed risks to people's safety in a way that considered their individual needs and promoted their independence. There were enough staff to keep people safe and recruitment procedures were designed to prevent people from being cared for by unsuitable staff. Medicines were managed safely.

Staff received appropriate training and support to ensure they had the knowledge and skills needed to perform their roles effectively. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People received a variety of nutritious food that met their individual needs. They received the support they needed to stay healthy and to access healthcare services.

People received personalised support that was responsive to their individual needs. Staff were aware of people's needs, goals, abilities, likes and dislikes. People received support to maintain contact with their families and to meet their religious and cultural needs. People took part in a range of individual and group activities to suit their abilities and interests.

The service had an open and transparent culture. People felt comfortable raising any issues they might have about the home with staff. The service had arrangements in place to deal with people's concerns and complaints appropriately. The provider also routinely gathered feedback from people and their representatives through surveys. They used feedback alongside their own audits and quality checks to continually assess, monitor and improve the quality of the service. The service had a clear vision and values and demonstrated an inclusive and empowering culture where people were involved in the day to day running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. We found that appropriate action had been taken by the provider to meet legal requirements and ensure the service was safe.

There were robust safeguarding and whistleblowing procedures in place. The fitness and suitability of new staff was checked by the provider before they could work at the home. There were enough staff to meet the needs of people using the service.

People were given their prescribed medicines at times they needed them.

Is the service effective?

Good

The service was effective. We found that appropriate action had been taken by the provider to meet legal requirements and ensure the service was effective. Specifically, staff received up to date and relevant training to ensure they had the right knowledge and skills needed to perform their roles effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People received a variety of nutritious food that met their individual needs. They received the support they needed to stay healthy and to access healthcare services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. We witnessed some instances where staff failed to respect people's dignity.

People spoke positively about staff. People's views about their preferences for care and support had been sought.

Is the service responsive?

Good

The service was responsive. People were involved in discussions and decisions about the care and support they would receive. Care plans reflected people's needs, choices and preferences

which ensured staff understood how to respond to these.

People were encouraged to maintain relationships with the people that were important to them. Staff actively encouraged and used innovative ways to keep people active and to support them to pursue a wide range of meaningful activities both within the home and in the wider community.

People felt comfortable raising issues and concerns with staff. The provider had arrangements in place to deal with complaints appropriately.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The provider had taken action to improve the way they monitored the quality and safety of the service people who lived at the home received. Specifically, the provider had improved its arrangements for preventing and managing falls and staff training.

However, whilst we saw the provider had made some progress to improve the effectiveness of their quality monitoring arrangements, further action is still required. This was because the providers arrangements for quality monitoring staff practice through random observations and spot checks by managers had failed to identify that some staff did not always treat and care for the people they were supporting in a respectful and dignified way.

People's views were sought and valued. They were involved in developing the service. Staff also felt valued and listened to and were involved in improving the service.

Sutton Court Care Centre

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 9 and 12 December 2016. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed the information we held about the service, including the statutory notifications we received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our two-day inspection we spoke with 18 people who lived at the home, six people's relatives and four visiting community healthcare professionals, which included a doctor from the local GP practice, a consultant clinical psychologist, a hospice palliative care nurse and a Clinical Commissioning Group (CCG) health care nurse assessor. We also talked to various members of the service's management and staff team that included the registered manager, one of the directors, the head of operations, a care consultant, the clinical nurse lead, two other registered general nurses (RGNs), 12 health care workers, the activities coordinator, a cook and a cleaner.

We also undertook general observations throughout our visit and used the Short Observational Framework for Inspection (SOFI) during lunch on the home's first (dementia unit) and second floors. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we look at included 12 people's care plans and associated risk assessments , six staff files and a range of documents that related to the overall management and governance of the service, including medicines administration records (MAR) and complaints records.

As part of the inspection process we also contacted two external social care professionals to ask for their feedback about the home.

Good

Is the service safe?

Our findings

People told us they felt safe living at the care home. One person said, "I feel safe in the home." Another person told us, "I think we're very safe here. They [staff] always leave the bed rail up when they leave as I'm terrified of falling out of bed."

At our last inspection of the service in May 2016 we rated this key question 'Requires Improvement'. This was because we found the provider had breached regulations. Specifically, we found gaps in risk assessments in respect of preventing falls and mitigating risks associated with the moving and handling of people using the service.

At this inspection we found the provider's risk management arrangements had been significantly improved. The provider now identified and managed risks appropriately. One person told us, "I nearly had a fall the other day, but staff came quickly to help me so I didn't hurt myself." We observed staff supporting people to move and transfer safely throughout our inspection. For example, we saw two staff take their time to calmly help a person transfer from their wheelchair to an armchair. Staff used the correct moving and handling equipment and ensured the person they were supporting knew exactly what they were doing. We also saw several instances of staff following behind people who were using a Zimmer frame at a respectful distance to ensure their safety.

Where there was a risk of harm to people, there were plans in place to ensure these risks were prevented or appropriately managed. People's care plans clearly identified risks to people's safety and management plans were in place for staff to follow to mitigate those risks. For example, we saw falls prevention and manual handling risk assessments had been carried out and/or reviewed by the provider's physiotherapist in the last six months for everyone who lived at the home. Records showed new staff received moving and handling training as part of their induction and for all existing staff it was mandatory for their moving and moving knowledge and skills to be refreshed annually. Staff demonstrated a good understanding of the specific risks each person faced and how they could protect people from the risk of injury and harm, for example through falls prevention and safe manual handling techniques.

The registered manager reviewed all incidents of falls at the home on a monthly basis to identify any trends or patterns, including the time and location it had occurred. These monitoring records showed the number of falls people using the service had been involved in had significantly decreased in the last three months. Equipment such as hoists and mobility aids was checked and serviced regularly to ensure they remained safe to use.

There were sufficient numbers of staff deployed throughout the home. People told us there were usually enough staff available when they or their family member needed them. One person told us, "I've never experienced delays from staff helping me to get up and ready in the mornings." Another person's relative said, "There always seem to be lots of staff about whenever I visit my [family member]." Two community healthcare professionals also told us the area used by people living with dementia had been well staffed when they had visited their clients there.

Throughout our inspection we saw staff were visible in communal areas, which meant people could alert staff whenever they needed them. Most people told us staff turnover rates had significantly improved in the last six months. One person said, "I think the home must be close to being fully staffed after their massive recruitment drive in the summer. It means there's a lot of new faces about, but to be fair to them [staff] they all seem to be decent people and keen to stay." Another person told us, "The team seems to be a lot more stable at the moment. They [managers] seem to be much better at holding onto to new staff these days." We saw numerous examples of staff attending immediately to people's requests for a drink or assistance to stand. We saw the staff rota for the service was planned in advance and took account of the level of care and support people required in the home. We also saw one-to-one staff support was provided to people assessed as requiring this additional staff support during the day. The staff duty rosters showed staffing levels were determined according to the number and dependency levels of the people using the service.

The provider ensured appropriate recruitment checks were carried out on all new staff before they started working at the home. Staff records showed the provider undertook employment checks in respect of the entire staff team, which included proof of their identity, the right to work in the UK, relevant qualifications and experience, character and work references from former employers, a full employment history and criminal records checks. Staff were also expected to complete a health questionnaire which the provider used to assess their fitness to work.

The provider had safeguarding adults at risk and whistle blowing policies and procedures in place for all staff to follow. These outlined how and when to report any concerns they might have. The policies and procedures were accessible to all staff in their induction handbooks, which they were given when they first started working at the home. All staff received safeguarding training annually, which also formed part of their initial induction. Staff we spoke with were knowledgeable about how to recognise the signs that a person may have been subjected to abuse or neglect and were aware of their responsibilities to report any safeguarding concerns they might have. A staff member told us, "I have never witnessed anyone who lives here being abused, but if I did I would tell one of the managers or senior nurses about it straight away."

Medicines management in the home was safe. People told us they received their prescribed medicines in a timely and correct way. We found all prescribed medicines at the service were stored securely in locked medicines cupboards located within each person's room. Medicines records showed people had individualised medicines administration (MAR) sheets that included their photograph, a list of their known allergies and information about how the individual preferred to take their medicines. Our checks of stocks and balances of people's medicines confirmed these had been given as indicated on people's MAR sheets. Staff received training in the safe management of medicines and their competency to handle medicines safely was assessed annually.

Good

Is the service effective?

Our findings

People told us they felt staff were well trained. One person said, "Staff seem to know what they're doing." Another person's relative remarked, "I think the staff are trained because most of them seem to be pretty good at their job, and that includes all the new ones as well."

At our last inspection of the service in May 2016 we rated this key question 'Requires Improvement' because the provider was in breach of the regulation in relation to supporting staff. Specifically, we found that not all staff had received up to date moving and handling training, which meant staff might not have had the right knowledge and skills to meet people's needs.

At this inspection we found the provider had taken appropriate action to follow their improvement plan and address the staff training issues we identified at their last inspection. We observed staff on two occasions working in pairs to transfer people appropriately using a mobile hoist. Training records indicated staff had refreshed their moving and handling training within the past six months by attending a practical moving and handling session facilitated by a physiotherapist employed by the provider. This was confirmed by staff we spoke with who also demonstrated a good understanding of their moving and handling roles and responsibilities.

Staff received a thorough induction that included shadowing experienced members of staff when they started work at the service. Systems were in place to ensure staff stayed up to date with training considered mandatory by the provider. Records indicated staff training was appropriate for them to be skilled enough to meet needs of people using the service. For example, we saw all staff had received dementia awareness and end of life care training. Nursing staff received additional training in clinical areas including catheterisation and managing percutaneous endoscopic gastrostomy (PEG) feeding. PEG is a medical procedure in which a tube is inserted into a person stomach and is used to feed people who are unable to eat orally (for example, because of difficulty to swallow). Staff told us the training they received helped them effectively carry out their roles and responsibilities. One member of staff said, "The training is very good here. Recently I've attended training courses on dementia, palliative care, moving and handling and safeguarding."

Despite the range of training staff received, records indicated that they had not received training on equality and diversity. This was confirmed by staff. We discussed this with the registered manager who agreed to find out more about equality and diversity training to help staff have a better understanding how to protect people from the risks associated with discriminatory practices and behaviours.

Staff received an annual appraisal and had one-to-one supervision on a two-monthly basis to give them opportunities to discuss their work and to provide them with the support they needed to work well. Several members of staff told us they felt they got all the support they needed from the management team. Managers told us that in addition to the meetings described above they regularly carried out direct observations of staff performing their care duties at the home.

Staff were aware of the importance of seeking consent from people when offering them support. One member of staff told us, "I would not do anything for anyone unless I asked them if it was okay to do so. I wouldn't force anyone to do anything if they didn't want to."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home 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 and staff demonstrated a good understanding of the MCA and DoLS. Records indicated managers and staff had all received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training. We saw that the provider had assessed people's capacity to make specific decisions about their care. Where the registered manager had concerns regarding a person's ability to make specific decisions they had worked with them, their relatives if appropriate, and any relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA. We saw ten applications to deprive people of their liberty for their own safety had been authorised by the local authority. All of the appropriate documents were in place and kept under review and the conditions of the authorisations were being followed by staff.

Staff ensured people ate and drank sufficient amounts to meet their needs. Most people told us the meals they were offered at the home were generally "good" and that they were always given a choice. Typical comments we received included, "The food can be a bit up and down sometimes, but it's generally ok", "I like the food here and you always get a choice" and "The food is very good. The fish and chips we had today was nice". We observed lunch being served in two dining rooms during our inspection and saw the meals people had chosen looked and smelt appetising. We saw care plans included information about people's food preferences and the risks associated with them eating and drinking, for example where people needed a soft or pureed diet. Staff demonstrated a good awareness of people's special dietary requirements and the support they needed.

People were supported to maintain their health. Several relatives told us staff were quick to get medical assistance for their family members when they required it. A visiting GP said staff did not hesitate to contact the surgery for medical advice if they were concerned about the health of people they supported. The GP also told us they did not have any concerns about the quality of care provided at the home and the competency of staff who worked there. We saw people's care plans contained important information about the support they needed to access healthcare services such as the GP or dentist. People's health care and medical appointments were noted in their records and the outcomes from these were documented. Staff monitored people's general health and wellbeing and recorded he information daily. Staff we spoke with were knowledgeable in recognising signs and symptoms that a person's health was deteriorating and the action to take.

Requires Improvement

Is the service caring?

Our findings

People typically summed up their experiences of living at the home as "OK" and frequently described the staff as being "nice". Comments we received included, "It's OK here. Staff are always kind and attend to my needs. I like it at the home", "The staff are OK. [Staff are] nice people" and "I can't fault the place. [Staff] are the absolute tops. Nothing is too much trouble."

Most staff we observed supported people in a kind and compassionate way. For example, we saw a member of staff taking their time to sit and patiently listen to a person telling them how frustrated they were not knowing why it was taking so long for staff to help them get up and dressed that morning. The member of staff defused the situation to the individual's satisfaction by calmly explaining to them what had caused the delay and immediately arranged for staff to help them get ready. Furthermore, we saw people looked at ease and comfortable in the presence of staff and most conversations between staff and service users were characterised by respect, warmth and compassion.

However, despite the positive comments and observations described above we saw some staff did not always treat people in a caring and dignified way. For example, we observed one member of staff use inappropriate language whilst speaking to a person using the service. We discussed this incident with the registered manager who took appropriate action to immediately suspend the member of staff concerned while the matter was investigated. In addition, the way staff interacted with people who needed support to eat and drink was mixed. We observed 12 members of staff assisting people to eat their lunch on the first day of the inspection and saw only half of them attempted to make any eye contact, explained what was on people's plates or engaged in any conversation with the people they were supporting. This lack of communication meant some staff did not always treat people who needed help to eat and drink in a caring and compassionate way.

The provider was in breach of regulation 10 of the HSCA (Regulated Activities) Regulations 2014.

Records were kept securely within the home so that personal information about people was protected. Staff records showed all staff had signed agreements that information about people would be respected and kept confidential. We observed staff did not discuss personal information about people openly.

People were supported to maintain relationships with their families and friends. Relatives told us they were free to visit their family member whenever they wanted and were not aware of any restrictions on visiting times. A relative said, "Staff are always welcoming and I've never known there to be any restrictions of visiting times." Community healthcare professionals also told us staff always made them feel welcome whenever they visited the home. We observed staff were welcoming towards all visitors and took time to say hello and speak with them. We saw care plans identified all the people involved in a person's life and who mattered to them.

Although most people living in the home were highly dependent on the care and support they received from staff with day to day activities and tasks, staff still encouraged people to be as independent as they could be.

For example, we saw people could move freely around the home. We also observed people who were unable to use traditional cups and plates had their needs assessed and where appropriate, had been given a plate guard or special crockery which enabled them to drink and eat with minimal assistance from staff. It was evident from records we looked at and comments received from managers that people who were willing and capable of managing their prescribed medicines safely were encouraged and supported by staff to do so.

When people were nearing the end of their life, they received compassionate and supportive care. A visiting community palliative care nurse was complimentary about the standard of the end of life care provided by staff at the home and the compassion they demonstrated. Staff told us they asked people for their preferences in regards to their end of life care and documented their wishes in their care plan. This included conversations with people, and their relatives, about their decision as to whether to be resuscitated and whether they wanted to be hospitalised for additional treatment and in what circumstances. Staff confirmed they had received end of life care training.

Good

Is the service responsive?

Our findings

One person's relative told us, "We get invited to meetings all the time about my [family member]'s care." Another relative said, "I feel the staff listen to what we have to say about how best to look after our [family member]."

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People's care plans showed that before they moved into the home their needs were assessed through a pre-admission assessment process. We saw copies of these assessments in all of the care plans we looked at. Care plans recorded people's preferences, their life histories and their diverse needs. Care plans described the support people required from staff, for example, with their communication methods, mobility needs and support they needed with personal and nursing care. All of the care plans and risk assessments we looked at were reviewed and updated monthly and reflected people's changing needs.

Staff were responsive to people's changing needs. For example people were weighed regularly to monitor their nutritional needs. We saw staff completed fluid and dietary charts on a daily basis and would escalate concerns to the nursing staff if a person did not eat or drink during the day. Staff said there were handover meetings at the end of each shift where they shared any immediate changes to people's needs. This ensured people received continuity of care.

People were supported to pursue social activities and interests that were important to them. People told us there were activities to take part in and said they were generally "OK". Typical comments we received included, "There's lots of things going on. I enjoy the singing and the Christmas party we had at the home recently", "I like doing arts and crafts and this year I helped make some Christmas decorations" and, "I like to read the newspaper, which is delivered to the home every day." We also saw a member of staff braiding a person's hair and this appeared soothing and relaxing for this individual.

We saw a calendar of weekly activities available to people displayed on notice boards throughout the home. This included quizzes, gentle exercise classes, pampering sessions, sing-alongs, a knitting club, flower arranging, dominoes, bingo and live music. Whilst talking with the activities coordinator, they told us they had not received any specialist training so they had a better insight in relation to providing meaningful social activities for older people or people living with dementia. We discussed this with the registered manager who agreed to send the activities coordinators on an activities course designed to improve the quality of life for people living with dementia.

Staff supported people to practice their faith and in line with their cultural preferences. Celebrations were held at the service to acknowledge religious festivals which had recently included Diwali and Christmas. The home was decorated for Christmas and we saw that staff took people out in the provider's minibus to attend a Christmas carol concert at a local school. The activities coordinator told us about a Christmas party the provider had organised for people living in the home and their relatives. We saw evidence that spiritual leaders representing Christian and Muslim faiths regularly visited the home. The director told us about a group of people from the local community who attended a nearby mosque who visited the home during the

Christmas period to bring gifts to people who use the service.

The provider responded to complaints appropriately. People and their relatives told us they felt able to raise a complaint if they had any concerns or were not happy about the standard of care provided at the home. One person told us, "I'll go and see the manager if something's not right. The manager does listen to what I have to say."

The service had a procedure in place to respond to people's concerns and complaints which detailed how these would be dealt with. The complaints procedure was displayed throughout the home and explained what people should do if they wished to make a complaint or were unhappy about the quality of the service they received. Staff were aware of the complaints procedure. They told us they would support people if they wanted to make a complaint and would ensure any complaint was reported to the registered manager so it could be dealt with.

The provider had a positive approach to using complaints and concerns to improve the quality of the service. Complaints were dealt with by the registered manager. The complaints records showed that any concerns had been taken seriously, investigated, action taken and lessons learnt. We saw that outcomes from complaints were linked to change of practice when necessary.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service in May 2016 we rated this key question 'Requires Improvement'. This was because the provider did not have effective systems to monitor and ensure that care to people was always delivered in a safe manner. They had not ensured that risks in relation to people falling were regularly reviewed and updated and staff received moving and handling training that was updated annually. This meant people might have been at risk of receiving unsafe care from staff who were not properly trained.

During this inspection we found the provider had taken appropriate action to follow their improvement plan and address most of the quality monitoring issues we identified at their last two inspections. Care plans we looked at contained up-to-date falls prevention and moving and handling assessments and we saw recorded evidence that staff had received moving and handling training in the past six months.

However, whilst we saw the provider had made some progress to improve the effectiveness of their quality monitoring arrangements, further action is still required. This was because the providers arrangements for quality monitoring staff practice through random observations and spot checks by managers and senior nurses had failed to identify that some staff did not always treat and care for the people they were supporting in a respectful and dignified way. For example, we observed a member of staff use inappropriate language when talking to a person who lived at the home and six other staff not engaging properly with people they were assisting to eat their lunch.

There were appropriate arrangements in place for monitoring the quality of the service that people received. Records indicated managers and senior nursing staff conducted a range of daily, weekly, quarterly and annual checks at the home. This included spot checks to look at the cleanliness of the building, regular audits of care plans and risk assessments, staff recruitment, training and support, and management of medicines.

The provider dealt with accidents and incidents appropriately. Accident and incidents were checked and analysed at regular intervals in order to determine if there were any identifiable trends. Staff knew how to record any accidents and incidents that took place and there were systems in place for the provider to learn from these and improve the safety of the service as a result. The registered manager gave us a good example of how the service had significantly reduced the number of falls in the home by analysing information obtained as part of the provider's newly introduced monthly falls audit. Where issues had been found appropriate action had been taken to refer people to the relevant community health care professionals, update their falls prevention risk assessments and to share these findings with staff during handovers and other meetings. We also saw reports produced by the providers care consultant who carried out biannual audits of the service.

The service had a registered manager in post. The registered manager had worked at the service for several years and knew the staff and the people who lived there well. People spoke positively about the registered manager's leadership style. One person told us, "The manager is good", while another person said, "The owner and manager were very nice and easy to talk to." A visiting health care professional was equally

complimentary about the way the home was run. They told us, "I find the manager very knowledge and approachable."

Managers promoted an open and inclusive culture which welcomed and took into account the views and suggestions of people using the service. People and their relatives told us they were actively encouraged and supported to share their views about the home. The provider used a range of methods to gather people's views and/or suggestions which included regular residents and relatives meetings, a monthly newsletter and annual satisfaction surveys. The registered manager gave us a good example of how the service had responded to feedback they had received from people's relatives about the lack of community based activities on offer at the home which the provider had addressed by purchasing a minibus.

Managers valued and listened to the views of staff working in the home. Staff spoke favourably about the management team and said they were always approachable and helpful. Staff also described Sutton Court Care Centre as being a "good" place to work. One member of staff said, "Although a lot of us are new and are from lots of different countries we all get on very well", while another member of staff told us, "I love working at the home. Everyone is so nice". Staff confirmed they were able to express their views at regular team and individual meetings held at the home with their managers and co-workers.

The registered manager demonstrated a good understanding of their role and responsibilities particularly with regard to legal obligations for ensuring compliance with CQC registration requirements and for submitting statutory notifications of incidents and events involving people using the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure people using the service were treated with respect and dignity at all times. Regulation 10 (1)