Habilis Operations Limited

Sutton Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sutton Lodge Residential Care Home provides personal care for up to 24 older people in one single storey building. At the time of the inspection 18 people were supported some of whom were living with dementia.

People's experience of using this service and what we found
We found multiple concerns at this inspection relating to the safety of the environment and management of people's care needs. In addition, the provider had not ensured authorisation was sought when people were deprived of their liberty when in receipt of their care. The provider had not ensured staff had received up to date training or that enough staff were available to ensure people received safe, person-centred care.

Following the inspection, we met with the provider to discuss our concerns. As a result, the provider has made the decision to close the service. We will continue to work closely with the provider and local authority until people have moved to alternative accommodation. Where a service is rated inadequate overall it would usually be placed into special measures. This is a process which ensures the service is monitored closely. Because the provider has made the decision to close the service on this occasion it will not be placed into special measures.

The impact of the concerns were that people's care and support was not planned effectively to meet their needs in the way they preferred. Not all areas of support people required were met and they were at times in distress or anxious because of this. Staff did not have enough time to spend with people and this meant people were at risk of isolation.

Staff had not received up to date training to ensure they knew how to manage people's care safely in line with legislation and best practice. This placed people at risk of avoidable harm.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 6 March 2018). The service had been rated requires improvement four consecutive times prior to this current inspection. The provider completed an action plan after the last inspection to show what they would do and by when to improve. Enough improvement had not been made at this inspection and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safety of the premises and management of risk, staff training and staffing levels, person-centred care and safeguarding of people from improper treatment, in addition to the provider's oversight of the service. Please see the action we have told the provider to take at the end of this report.

Follow up
The provider made the decision to close the service following the inspection. We will work with the provider and local authority until the service is closed to ensure people are moved to alternative accommodation safely.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Sutton Lodge Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors carried out this inspection.

Service and service type
The service is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on day one and we told the provider we would be visiting on day two.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and two relatives about their experience of the care provided. We spoke with 11 members of staff including the provider, registered manager, mentor manager, senior care workers, care workers, kitchen staff and activities worker. We spoke with three visiting professionals.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with a healthcare professional and fire officer about the service. We met with the provider to discuss our findings.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. They had failed to do all that was required to reduce the risk of avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 12.

• People were not safe in the event of a fire. The provider had failed to carry out essential work to ensure the building was safe in relation to fire protection. This work has been outstanding since 2014. Staff had not received training around fire evacuation and the provider's evacuation procedure had not been tested to ensure it would work in an emergency.
• People were not protected from avoidable harm because risk was not always recognised in the environment and the equipment used. For example, hot water temperatures were too high in some cases and people could be scalded. Not all equipment had safety checks completed and some equipment was not safe. People living with dementia had access to things that could harm them such as hot water outlets, other people's medicines and the main road via an unsecure perimeter gate.
• Where risks had been highlighted in relation to people's care needs the provider did not have up to date risk assessment tools and care plans. Therefore, staff were not aware of all the control measures that were needed to prevent harm. For example; specialist equipment to prevent serious injury if people fell from bed was not in place.
• Where people became anxious a care plan was not in place to guide staff in how to intervene in the most effective way to prevent distress.
• Care plans and risk assessments were not reviewed following accidents to understand what could be done to prevent further accidents.
• Staff did not always follow good infection control practices to help prevent the spread of healthcare related infections. For example, staff were observed carrying dirty laundry which was not in a sealed bag or container through communal corridors. Parts of the environment had not been maintained to allow for effective cleaning; for example, bathroom flooring.

The lack of systems to fully understand risk and do all that is reasonably practicable to reduce the likelihood of harm was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection Lincolnshire Fire Authority visited the service. They worked with the provider to reduce the risk of harm to people in a fire situation as an interim measure until further work could be organised. Part of this work included four people being moved from this service to ensure evacuation in an emergency was safe for the remaining people.

Using medicines safely
• People were at risk of harm because staff did not have clear instructions from the prescriber to know how to administer certain medicines. For example, a person who was at risk of choking was prescribed a thickener for their drinks. Such thickener needs to be used in different quantities for different swallowing difficulties. The prescription did not guide staff on what to do. Staff had not recognised or challenged this issue and therefore people were still at risk of choking.
• One person had a specific medical condition that required monitoring of their heart before their medicines could be administered safely, this had not happened.
• The provider did not have up to date procedures in place for staff to follow. Where people were prescribed 'as and when required' medicines guidance for staff to follow were not in place. Staff therefore did not have all the information required to know when to administer them.

The lack of up to date policies to fully implement safe medicines systems placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Staff were observed to be very busy. People's immediate needs were not neglected. However, people's social and personal care needs such as oral hygiene and nail care were not always met.
• The provider had a system to check people's level of need, but it did not determine the number of staff that were needed to care for people safely. For example; the number of staff needed to safely evacuate the building.

The lack of an effective system to determine safe staffing levels placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider operated a safe recruitment process.

Systems and processes to safeguard people from the risk of abuse
• The provider had safeguarding systems in place. Staff knew what to do to raise concerns. Training in this area was not up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Staff had not received a robust induction or ongoing training to enable them to have enough knowledge to fulfil their role.
• Where people had specific health needs such dementia, pressure area care and swallowing difficulties staff had not received any training.
• The registered manager had not received any supervision or appraisal from the provider.

The lack of training to provide staff with up to date knowledge to enable them to perform their role placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff had opportunity for support, supervision and appraisal.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Where people required support from healthcare professionals this was arranged. The guidance provided was not always recorded in people's care records and it was difficult to determine if staff were following the correct advice. Some healthcare professionals had not supported the staff to understand how they should care for people. For example, prescriptions for fluid thickener were not clear and people were still at risk of choking because of this.
• Information was recorded and ready to be shared with other agencies if people needed to access other services such as hospitals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments of people's needs did not include all areas of care people may requires support with. Oral care and nailcare, health and communication needs were areas not assessed or planned for.
• People's experience of using the service was negatively affected because staff did not review their progress or outcomes regularly. For example; some people had not been weighed for many months. One person had not had their weight monitored since May 2017.

Supporting people to eat and drink enough to maintain a balanced diet
• People's weight was not monitored to understand if people required professional input. Where people drank very little fluid staff did not monitor them for dehydration.

• Staff supported people to understand the menu choices. Where needed, people had access to adapted cutlery and equipment, so they could eat and drink independently. Where people required specialist diets this was catered for.
• People enjoyed their food. One person told us, "It's good home cooking."

Adapting service, design, decoration to meet people's needs
• The environment had not been assessed or adapted to ensure people living with dementia could be safe and maintain their independence. For example, hot water was freely available creating a risk of scalding.
• The environment needed refurbishment. The provider had started to make some improvements but had no clear timescales of when the work would be completed.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People living with dementia had not been assessed under the MCA to understand if they were aware of the restrictions on their liberty which meant they were deprived of this.
• Some people were observed to have little understanding of their situation or restrictions placed on them, such as their inability to leave the service.
• No applications had been made to authorise such deprivations of liberty.
• The registered manager completed assessments of people following day one of inspection and made six applications to seek authorisation to deprive people of their liberty.

To deprive a person of their liberty whilst they receive care is not lawful unless an application to seek authority is made. Therefore, this was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff knew what they needed to do to make sure people consented to their daily care. However, records to evidence consent were confused and showed a lack of understanding about the MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People were not always afforded privacy and dignity. We observed that staff had not closed a bedroom door when a person, who was undressed, was sat on their commode. We also saw staff entered people's private bedrooms without seeking consent to enter.
• People were supported to focus on their independence where possible. One person used a walking aid to access parts of the service they wished to.

Supporting people to express their views and be involved in making decisions about their care
• Staff supported people to make decisions about their care; and knew when people wanted help and support from their relatives. Where needed they sought external professional help to support decision making for people such as advocacy.
• Relatives did not always feel staff had the time to spend with them to involve them in their family member's care. Because of this they were left in a position where they did not know what was happening.

Ensuring people are well treated and supported; respecting equality and diversity
• People were treated with kindness. One person told us, "The best thing here is the staff. They are what matter. They try, and they are lovely, never rude to me. They are all so nice."
• Work to support staff to understand people's life history was underway. This is a known way of staff developing positive relationships with people.
• Where people were unable to express their needs and choices, staff had worked to understand their way of communicating. Staff observed body language, eye contact and used symbols to interpret what people needed.
• Staff showed genuine concern for people and were keen to ensure their rights were upheld and that they were not discriminated against in any way.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• Staff knew people's likes, dislikes and preferences. They used this detail to care for people in the way they wanted. The detail was not recorded in the care plan. People therefore were at risk of receiving care in a way they did not prefer.
• Care plans did not contain a description of how to care for people in areas such as nail and skin care, communication and activities. Therefore, people did not always receive care when they needed it. We saw one person had dirty nails and others who did not receive support to enjoy activities and socialising with others.
• Care plans were not reviewed appropriately to ensure people had received the care they required or that they had positive feelings of wellbeing.
• Staff had little time to spend with people and people spent a lot of time in their own rooms or in the main lounge watching TV. People did not have enough support to avoid social isolation.

Care was not always appropriate to people's needs or in line with their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People who accessed the activities on offer told us they enjoyed them. A new activities worker had been employed who had spent time with people to understand their likes and dislikes and had started a programme to meet people's needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People's communication needs were not identified, and therefore a care plan to help staff understand how to communicate was not in place. The impact this had on people is described above in relation to person-centred care.

Improving care quality in response to complaints or concerns
• People and relatives knew how to make complaints should they need to. They told us they believed they

would be listened to by the new registered manager.
• The registered manager acted upon complaints in an open and transparent way. They used any complaints received as an opportunity to improve the service.

End of life care and support
• Staff worked in conjunction with the local healthcare professionals to ensure people received a pain free and dignified end of life.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to suitably assess, monitor and improve the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 17.

• The provider's policies and procedures were out of date and did not link to safe or current best practice. Therefore, the registered manager had inadequate guidance and up to date leadership on how to deliver safe and effective care. For example, in areas such as medicines, falls and infection control management.
• The provider had not ensured there were systems in place to check the safety and quality of the service thoroughly. This had led to the multiple breaches of regulations described in this report.
• The provider had failed to act when safety and quality issues had been brought to their attention by their own fire risk assessor, the fire authority and CQC. This placed people at continued risk of harm and in receipt of poor-quality care.
• The provider had failed to ensure the registered manager received the appropriate induction and support to enable them to fulfil their role. For example, the registered manager was unaware of the need to make applications to deprive people of their liberty.
• We discussed with the provider the need for a more robust governance of the service. This included ensuring changes were in line with current best practice or legislation. And that they must carry out checks to ensure safety and quality.

Failure to establish and operate systems and processes effectively placed people at risk of harm and in receipt of poor-quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider and registered manager wanted people to receive a good quality service but were unable to provide the leadership to drive sustained improvements.
• Staff told us they felt listened to and that the registered manager was approachable. Staff did not always

take their responsibilities seriously and carry out their role as they were instructed. For example, staff meeting minutes clearly directed staff to complete records clearly and this had not always happened.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Since their employment, the registered manager had displayed an open approach to staff, people and their relatives and listened when things went wrong.
• We met with the provider following inspection and they reflected on the feedback received. They made the decision to close the service to ensure people were appropriately supported and safe in an alternative setting.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives had completed a survey of their views. Feedback had been used towards continuous improvement of the service.

Working in partnership with others
• The service had good links with the local community and key organisations to support the people in their care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care people received was not person-centred and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safety and risk were not appropriately assessed in relation to the environment, equipment and people's care needs. The provider had not acted when risk was highlighted to prevent avoidable harm. Medicines were not managed safely. Regulation 12 (1) (2) (a) (b) (c) (d) (e) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not in place to ensure the provider sought lawful authority to deprive people of their liberty for the purpose of receiving care. Regulation 13 (1) (2) (5)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to effectively assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The system to determine the number of staff required to meet people's needs was not effective. Staff had not received sufficient training to enable them to perform their role. The registered manager had not received sufficient training, supervision and support to enable them to carry out their duties.