Mr Barry Potton

Sutton House Nursing Home

Inspection report

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20 July 2016

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Sutton House Nursing Home is registered to provide personal and nursing care to a maximum of 38 people. It is situated in the village of Sutton, close to local amenities. The home has three floors serviced by a passenger lift and stairs and has a range of single and shared bedrooms. There are several communal areas for people to use and a garden at the front and the side of the building. There is a small car park at the front of the building.

The service had a manager in post as required by a condition of registration and they had started the process to be registered with the Care Quality Commission. 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.

We undertook this unannounced inspection on the 14 and 20 July 2016 to follow up progress with requirement notices for concerns we had with person-centred care, staffing and quality monitoring at the inspection we completed on 2 and 3 February 2016. At the time of the July 2016 inspection there were a total of 34 people living in Sutton House Nursing Home.

As we have not completed a full inspection, we have not changed the overall rating for the service, which remains at 'Requires Improvement'. We will be monitoring the service and completing further inspections to check on progress.

We had concerns with how staff monitored two people when one of them had a fall and sustained a head injury and the second person had an unresponsive episode for five minutes. We found staff did not have clear guidance on the action to take following such incidents and recording of monitoring people was limited.

In answer to this we have used our urgent powers under s31 of the Health and Social Care Act 2008 and imposed a condition on the registered provider's registration regarding the management of accidents and incidents which affect the health and safety of people who use the service. You can see the timescales for the registered provider to be compliant with this at the back of the main body of the report.

We found some improvements had been made with the development of an audit system and seeking people's views. However, an important element of governance is about learning from past incidents to ensure practice is improved. We found there was a failure for lessons to be learned in an area of observing and monitoring people following incidents that affected their safety, health and wellbeing.

In answer to this we have issued a warning notice to the registered provider regarding Governance and lessons to be learned from accidents and incidents to prevent a reoccurrence. You can see the timescales for the registered provider to be compliant with this at the back of the main body of the report.

We found improvements had been made with regards to the numbers of staff on duty. At the last inspection, we had concerns there were insufficient numbers of staff to meet the needs of people who used the service. The numbers of staff on duty during the day has increased by two care staff and at night by one care staff. A nurse has been recruited for a new clinical lead role to oversee clinical issues and to be a link between the qualified nurses and the new manager, who is also a nurse. There has been some improvements regarding staff training and ensuring care and nursing staff are equipped with the skills required to support people safely. However, we had some on-going concerns regarding the level of skills demonstrated by some staff when people who used the service were involved in incidents which affected their safety, health and wellbeing.

We found there had been some improvements with the delivery of person-centred care and the development of individualised care plans. One care plan we looked at was very person-centred and contained lots of information about their preferences for how care was to be delivered. New care plans had been introduced and staff had started to input more personalised information into them. However, we found this was a slow process and important details were missing from some people's care files which could affect the care they received. We did find, however, that staff had a good knowledge of people's needs and how they were to be met.

You can see what action we have asked the registered provider to take, regarding the concerns in the two paragraphs above, at the back of the full inspection report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff did not have full guidance in how to deal with incidents such as falls resulting in head injuries, seizures and changing needs which affected the safety, health and wellbeing of people who used the service. Staff had not completed required observations and monitoring when people who used the service were involved in such incidents.

Although we saw numbers of staff had increased to appropriate levels, we had concerns about the competence of staff when managing incidents which affected the safety, health and wellbeing of people who used the service.

We have not changed the rating of this section and it will remain as 'Requires Improvement' until the next full inspection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was some improvements noted with the delivery of person-centred care but more work was required to ensure care plans and risk assessments had full information to guide staff in how to meet people's assessed needs.

We have not changed the rating of this section and it will remain as 'Requires Improvement' until the next full inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was some improvement with the re-starting of the quality monitoring system and the new manager had put in place measures to improve support, communication and aspects of practice. However, we had concerns about the effectiveness of the quality monitoring system to highlight were lessons could be learned to improve practice for the safety, health and wellbeing of people who used the service.

We have not changed the rating of this section and it will remain as 'Requires Improvement' until the next full inspection.

Sutton House 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to follow up progress made on breaches to regulations identified at the last inspection on 2 and 3 February 2016 and to look at the overall quality of the service.

This inspection took place on 14 and 20 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors for both days. We were accompanied by a local authority safeguarding officer on the first day of the inspection.

We checked our systems for any notifications that had been sent in since the last inspection in February 2016 as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority safeguarding and contracts and commissioning teams. We also spoke with one continuing health care professional about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with seven people who used the service and one of their relatives. We spoke with the registered provider, the new manager, the training manager, two nurses, a team leader, a senior care worker and two care workers.

We looked at eight care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as visits from health and social care professionals, and accidents and incidents. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest

meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota, minutes of meetings with staff and people who used the service and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

We found the lack of observation and monitoring following incidents which affected or potentially affected the safety, health and wellbeing of people who used the service was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response to this breach and will report on it when it is completed.

Although we recognised improvements had been made in staffing numbers, we had concerns about staff competencies in dealing with incidents which affected people's safety, health or wellbeing. We have judged the breach in Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 has not been fully met. You can see what action we have asked the registered provider to take at the back of this report. We will follow this up again at our next full inspection of the service.

At the last inspection on 2 and 3 February 2016, we reported that the local safeguarding team were investigating an incident when a person's health condition was not monitored sufficiently which potentially affected the timeliness of them receiving medical attention. This investigation has not been concluded yet.

During this follow up inspection, one focus was how staff monitored people's needs following incidents which affected or potentially affected their safety, health and wellbeing; we found there were concerns in some areas. For example, one person had an un-witnessed fall and sustained a head injury with a nose bleed. Nursing staff had contacted an out of hour's service during the night for advice and completed one set of observations, which were within the normal range. However, there were no further clinical observations completed until their GP visited two days later. This was contrary to good practice guidelines following falls and head injuries. Similarly one person was recorded as having an 'unresponsive episode' for five minutes one night. Nursing staff on duty had not completed any clinical observations to check their wellbeing. In both instances, staff had not recorded whether any increased visual monitoring had taken place during the night to assure themselves the people continued to be safe and not in need of medical attention. We found there was a lack of written guidance to inform staff as to what action to take following such incidents.

During the six days between the two follow up inspection dates, we saw the new manager had started to address our concerns by obtaining good practice guidance on how to manage, monitor and carry out observations on people who had an un-witnessed head injury or other similar incident; they had introduced monitoring forms and ensured staff were aware of them. They had also completed a supervision meeting with two qualified nurses to discuss appropriate actions to take following such incidents.

At the last inspection on 2 and 3 February 2016, we saw there was insufficient skilled and experienced staff to meet people's needs. This had impacted on the attention people should have received from staff and we had observed periods when people were left unsupervised. We observed that staff were rushed and tasks such as the administration of medicines took longer than expected. Since that last inspection, there has been an increase in staffing numbers, which was confirmed in discussions with people who used the service and with staff.

People who used the service told us they had noticed an increase in staffing numbers. They said staff looked after them well. Comments included, "I'm happy here, I really am; I wouldn't be here if I wasn't. I most definitely feel safe and there's always somebody around", "There's more staff now. If anyone gets up and is unsteady, someone shouts; the staff are always about and come straight away but they are usually in the lounge anyway", "Everything is fine, there are a few different staff. The new ones are really nice; all the staff are really friendly and the place is lovely. I feel safe here", and "I've been here a month and it's grand; the carers do an awful lot and they are lovely."

A visitor told us staff supported their relative to the toilet now, as they had experienced frequent falls. The visitor said, "When you pull the bell they come straight away; very good."

Comments from staff included, "When I first came here, staff were going off sick and I wondered what I had come to. Now we have nice care staff, extra seniors, extra team leaders and a good working team", "The residents seem happier, sickness levels have gone down and I don't have to worry before coming on [duty]", "We were very short staffed and experienced and qualified staff went with the last manager; the deputy left shortly afterwards but now progress is being made", "It's getting better; there's more equipment and more staff" and "There's more time to speak to people [who used the service]. I'm glad we've got the additional staffing; that's down to [new manager's name]."

Staffing rotas indicated there had been an increase in care staff during the day and also at night. This meant there were now seven care staff and one nurse in the morning and five care staff and one nurse for the afternoon/evening shift. The day staff had a mix of skills which included care workers, senior care workers, team leaders and qualified nurses. There were three care staff and one nurse at night. The activity co-ordinator told us there was always a member of the activities team on duty from 10am to 7pm to support people with one to one and group activities; they said they were also available to oversee the main lounge at periods of high need. The service had a range of ancillary staff which enabled care staff to focus on care tasks. The new manager told us they had completed a dependency level check on each person who used the service and established the correct staffing levels to meet their assessed needs. On the first day of the follow up inspection, we observed an issue with deployment of staff in the lounge area for a specific length of time; there was no staff to oversee people and we saw some people who used the service telling others not to get up as they may fall. We saw this had been rectified by the second day and when people came into the lounge in the morning, there was a staff presence to oversee their needs.

Since the last inspection in February 2016, there had been progress made with training to ensure staff had the right skills and experience to support people. All staff had completed practical moving and handling and a basic awareness course which covered a number of specific areas considered essential by the registered provider. An audit of training had been completed and the registered provider's training manager was supporting the new manager in developing a training plan for the coming year. We saw there had been training for nurses and some care staff in the specific health care needs which some people who used the service had developed or had on admission.

Requires Improvement

Is the service responsive?

Our findings

Although we recognised some improvements have been made in the delivery of person-centred care, there remained concerns with the documentation used to guide staff such as risk assessments and care plans. We have judged the breach in Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 has not been fully met. You can see what action we have asked the registered provider to take at the back of this report. We will follow this up again at our next full inspection of the service.

At the last inspection on 2 and 3 February 2016, we had concerns that some people who used the service did not receive person-centred care. Also people's assessments and care plans did not fully include all important information to guide staff when supporting them. There was also an issue with how nursing staff responded to people following anomalies in blood pressure monitoring readings; the very low readings had not been followed up and equipment had not been checked.

At this follow up inspection, we found some improvements had been made regarding initial assessment of people's needs prior to admission to the service. New assessment documentation had been introduced and one person's care file we looked at had a detailed assessment and a full care plan. Other care plans had been reviewed and new documentation completed. However, we found risk assessments and care plans still required more work to ensure they had full information for staff.

We saw people's risk assessments described what the risks were and prompted staff to check care plans for information in how to minimise them. The risk assessments covered areas such as falls, moving and handling, nutrition, skin integrity and specific issues such as confusion. However, as some care plans did not contain full information to guide staff in how to support people, there was a concern important care could be overlooked. The risk assessments required much more detail with specific steps to guide staff in how to minimise risk. We discussed this with the new manager and training manager to ensure risk assessments and care plans could be further improved.

We found additional personalised information in people's care plans was required to guide staff in how to meet their needs in the way they preferred. For example, one person had been assessed as having a high risk of developing pressure ulcers but the risk assessment did not detail the measures needed to reduce risk and there was no care plan to guide staff as to the action to take to prevent pressure ulcers. The person had a recent pressure ulcer which had since healed so there was a risk of reoccurrence, although in discussions with staff they were able to describe the actions to take to prevent them from occurring. One person had been prescribed a medicine to reduce the number of seizures they had, which had been successful. However, there was no risk assessment and care plan to guide staff when supporting the person during seizure activity and no monitoring chart to use when recording them. Staff recorded the seizures in daily notes but there was no separate form that would provide information straight away as to type, length, recovery time and wellbeing of the person. One person was at high risk of falls but the risk assessment and care plan in place did not provide detailed guidance in how to minimise them and the action to take following an incident.

We found some people's care plans were vague regarding the support they required. For example, one person's care plan recorded they needed support to maintain a healthy weight but did not specify what range this fell into for them. It stated they required 'reassurance' but did not detail the specific action staff should take which would help to reassure the person. It stated staff were to observe non-verbal communication but did not identify what this may be or what it may indicate. Other care plans we looked at contained similar vague references to support which would not provide adequate guidance for staff.

We also saw some people had a 'physical intervention' care plan in place to be used if it was required. This was generic and did not specify what physical intervention was required and what would be the least restrictive practice for each individual person. This was discussed with the new manager and they told us they would be removed from people's care files and an assessment would take place on an individual basis should there be any need for any physical intervention. They said this would follow mental capacity, good practice principles; the new manager told us physical intervention was not required to meet the current needs of people who used the service.

We found information in some people's 'patient passports' conflicted with information in care plans and required updating. For example, one person's care plan stated they required a 'soft' diet but the patient passport stated they had a 'normal' diet. Patient passports are used to accompany people when they are admitted to hospital so nursing and medical staff have information about their current needs; it is important these are kept up to date. This was mentioned to the new manager to address.

We found there were some improvements with person-centred care. People who used the service told us staff supported them well and they felt staff knew how to look after them. Comments included, "The staff have good skills and help me with my exercises and meet my needs well", "If I'm ill they will ring the doctor and my tablets are always on time" and "They have discussed my care plan with me and we have meetings when things change. Staff bring me pain relief; they are really good. I get a bit ratty when I'm in pain but the staff are very understanding and all are nice." A relative who was very actively involved with their family member and visited daily said, "They [staff] do a good job; they are good with [Person's name]."

One person told us how staff were supporting them to lose weight by providing a special diet for them; they told us they had been successful with the diet. Another person described how staff were escorting them to hospital for an appointment as their relative was unable to take them.

In discussions with staff, they demonstrated a good understanding of people's needs and how to meet them. They gave examples of this even though the information was not recorded in care plans. For example, they described the non-verbal means one person used to communicate their need to use the toilet. We observed staff responded quickly when people were showing signs of distress by talking to them, holding their hand and demonstrating care and compassion.

We saw new blood pressure monitoring equipment had been purchased and faulty equipment disposed of. There was a more systematic approach in place regarding the need to monitor people's blood pressure.

Staff had responded to one person's needs, regarding a very high risk of falls, by providing a specialised chair; the person lacked capacity to consent to the chair and it restricted their movement. However, appropriate documentation was in place to show action and consultation had been taken to adhere to the Mental Capacity Act 2005.

We saw some people had been provided with special beds which enabled them to be set at a low height and reduced the risk of injury should they roll out of them. These were used when people were assessed as being

at high risk when bed rails were used. Staff had also responded by positioning sensor mats by people's beds and chairs when there was a high risk of falls. Prompts were visible to remind staff to ensure these were activated when people were in their bedrooms.

Requires Improvement

Is the service well-led?

Our findings

Although we noted there had been some improvement in governance regarding the appointment of a new manager, and re-starting the quality monitoring system with audits and questionnaires, we had concerns the system did not adequately ensure lessons were learned so practice could be improved in specific areas. We have judged this to be a continued breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response to this breach and will report on it when it is completed.

During this follow up inspection, we had concerns about a failure of the registered provider to learn from a previous incident involving a lack of monitoring when a person became ill; the incident is still under investigation. However, senior managers had viewed the person's care file and were aware of where improvements needed to be made regarding staff's monitoring of people's changing needs. During this follow up inspection, we found two instances when people's changing needs had not been managed in a safe way to ensure their health and wellbeing. Staff had not carried out appropriate observations and monitoring of the two people and although there were no lasting ill effects for the two people, the potential for serious harm was present. This showed us the registered provider had failed to take appropriate action to learn from incidents that could potentially affect the safety, health and wellbeing of people who used the service.

At the last inspection on 2 and 3 February 2016, we had concerns that the quality monitoring system had only been partially implemented since the previous registered manager left the service in September 2015. At this follow up inspection, we found the new manager had restarted the quality monitoring system. A full audit of the environment had been carried out on 24 February 2016. This had indicated specific actions to be taken to resolve shortfalls. Although some of the issues had been addressed, new equipment purchased and areas of the service cleaned, there was no plan with timescales for some of the other refurbishment of fixtures and fittings which needed replacement. However, the registered provider has been informed about the areas to address and will be producing an action plan with timescales. The new manager will follow this up with the registered provider.

We saw there were recordings of accidents which had occurred each month with location and time indicated and the new manager had collated these onto one form with the action taken for each individual. However, there was no analysis of the information to see whether it should result in a change of practice or staff deployment. Similarly, medicines were audited and spot checks carried out; these had identified specific issues but there was no action plan to address the shortfalls. The new manager told us these were addressed straight away with staff. However, by not detailing the findings in an action plan it was difficult to check what had taken place to address them and whether there was a need for staff retraining or disciplinary measures for recurring themes. These points were mentioned to the new manager to address.

We looked at two completed 'manager's monthly audit tools' for June 2016. The new manager had recorded which records had been checked such as people's weights, minutes of meetings, complaints, housekeeping schedules, maintenance checks, whether care plans had been reviewed and risk assessments completed.

The audits recorded that care plans were under review and would take some time to complete. One of them also commented on whether appropriate staffing numbers were in place and whether there were any staff vacancies. These monthly audits were seen by senior managers when they visited the service so they could have oversight of the issues and check if required action had been taken.

As part of quality monitoring since the inspection in February 2016, we saw there had been meetings with people who used the service, their relatives and staff so they were able to make their views known to the new manager. There had also been questionnaires for people who used the service and for staff to complete. The questionnaires had been analysed and answers collated. The staff questionnaire indicated specific areas to address and these were reported back to staff in a 'results page'. However, there was no action plan indicating who was responsible for addressing the comments, with timescales, made in the questionnaires from people who used the service; this made it difficult to audit if these had been addressed. There was no system yet to notify people of the results of questionnaires and what action had been taken to assure people their comments would be addressed. This was mentioned to the new manager to address.

People who used the service told us the new manager had been introduced to them and visited them on a daily basis to see if they were okay. Comments included, "The new manager [Name] often pops in and she is really nice" and "[New manager's name] has told me that if I have any problems or worries then I have to go to her; all I have to do is ask."

A relative told us communication had improved. They said, "The new manager is very receptive and listens" and "I haven't been told about a couple of things but it seems to be getting better and they let me know about appointments."

The new manager has applied to be registered with the Care Quality Commission but the process has not been completed yet. They told us they had been well-supported by the registered provider and senior management team for the organisation. They described an open culture and said they would feel able to raise concerns and were confident these would be taken seriously and dealt with quickly. The new manager also described supportive arrangements for staff to ensure they received formal and day to day supervision of their practice. Staff told us things had improved for the better since the new manager came to the service. For example, they said morale and teamwork had improved, there was a more consistent approach to staff and people who used the service, and work allocation was fairer. Staff told us the new manager had made a positive contribution to the service, was making a lot of changes for the better and listened to their suggestions and concerns. Comments included, "Paperwork and files have all changed; you can find what you need in files now", "There is a new form which shares things [work tasks each shift] out better. I find it better being on the floor [supporting people]; it is much more structured and the seniors know where we are" and "I love working here but it has been a struggle over periods when we had no manager. [New manager's name] is fine. I think she is a good manager and is approachable."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Although we recognised improvements have been made in the delivery of person-centred care, risk assessments and care plans required more information to guide staff in how to support people in the way they preferred. Regulation 9 (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had increased the number of staff on duty to meet part of this regulation, however they had not ensured staff were experienced in observing and monitoring people who used the service following incidents which affected their safety, health and wellbeing. Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure the risks to the safety, health and wellbeing of people who used the service, following incidents such as falls or changes in their condition was assessed and all that is reasonably practicable to mitigate those risks was carried out. Also the registered provider did not ensure the persons providing care and treatment had guidance and the competence and skill to carry out observations and monitoring safely following such incidents. Regulation 12 (1)

The enforcement action we took:

We have served a Notice of Decision under s31 of the Health and Social Care Act to impose a condition on the registered provider's registration regarding the management of incidents and accidents. They have to be compliant with this by 12 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has not ensured the audit system is effective so lessons can be learned and practice improved. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We have issued a warning notice for Regulation 17, Governance, to the registered provider. They have to be compliant with this Regulation by 19 August 2016