Hydefall Limited

Sutton Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We last carried out a comprehensive inspection of Sutton Court Care Centre on 6 October 2015 when we found the provider was in breach of a regulation. Specifically, we found the provider had failed to operate good governance systems to effectively monitor the quality and safety of the service people who lived at the home received. We rated all the key questions as good, except for well-led which was rated required improvement. The service was rated good overall. After the inspection the provider wrote to us to say what action they intended to take to meet their legal requirements in relation to the breach of regulation described above. Since the beginning of 2016 we have also received concerning information about the way medicines were managed in the home and the high number of serious injuries sustained by people after they had been involved in a fall at the home.

We undertook this unannounced focused inspection on 12 and 16 May 2016 to check the provider had implemented their action plan in regard to the breach of regulation identified at the October 2015 inspection and, to look specifically at what arrangements the service had in place to prevent falls and manage medicines.

This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Sutton Court Care Centre' on our website at www.cqc.org.uk'.

Sutton Court Care Centre is a four storey purpose built residential care home that provides accommodation, nursing and personal care for up to 63 older people. The home is divided into four distinct units which are located on each floor of the building. At the time of our inspection 61 people were using the service, 38 of whom were living with dementia. Four other people had mental health 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.

During our focused inspection, we found the provider had taken some action to improve the way they monitored the quality and safety of the service people who lived at the home received, which included closer scrutiny of staff's medication handling practices. However, the provider acknowledges more work needs to be done to improve how they operate their governance systems in order to make them effective over a sustained period of time. Specifically, the new governance systems the provider had introduced since our last inspection still failed to identify that up to date risk assessments were always available in care plans to mitigate the risk of people falling, and risks associated with moving and handling. The meant people might be at risk of receiving unsafe care and/or being harmed because risks to their health and safety was not always consistently assessed and reviewed.

We also found staff had not received training in some key aspects of their role, which included learning disability and mental health awareness. In addition, whilst we saw systems were in place to ensure staff remained up to date with most of their existing knowledge and skills, we found moving and handling training was not being refreshed at regular enough intervals. This meant staff might not have the qualifications, competency and skills to meet people's needs and/or keep people safe.

In addition, the service had experienced unusually high levels of staff turnover in the last 12 months. We discussed staff continuity with the registered manager. They told us they had recently recruited 20 new members' of staff which meant the home was now almost fully staffed, although the registered manager conceded that it would take time for all these new employees' to complete their induction and to familiarise themselves with the needs and preferences of the people they would be supporting. The registered manager also told us they had recently introduced staff exit interviews to help them understand why the home had experienced such high levels of staff turnover recently.

The issues outlined above notwithstanding we saw the provider had ensured sufficient numbers of staff were deployed throughout the home during our inspection. The provider carried out appropriate checks to ensure staff were 'fit' to work with people who lived at the home. People also received their medicines as prescribed and staff knew how to manage medicines safely.

The breach of regulation relating to good governance remains outstanding from the service's last inspection. We have taken enforcement action against the provider and have issued a Warning Notice because of repeated breaches of the Health and Social Care (Regulated Activities) Regulations 2014. We also identified two new breaches of the Health and Social Care (Regulated Activities) Regulations 2014 in relation to a failure by the provider to mitigate risks to people and others, and to ensure staff were suitably trained for every aspect of their role. You can see what action we told the provider to take in relation to these two breaches of regulations, at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. Staff had not always adequately assessed the risks to people's safety, particularly in regards to falls, and moving and handling.

The issue notwithstanding there were enough staff deployed throughout the home to meet the needs of people living there. The provider had checked the suitability and fitness of staff to work in the home. People were also given their prescribed medicines in a safe way and at times they needed them.

We have downgraded the rating for this key question from 'good' to 'requires improvement' and we will review our rating at our next inspection of this service.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. People's needs may not always be fully met because staff had not received training in some key aspects of their role. This included mental health awareness training.

In addition, whilst systems were in place to ensure staff remained up to date with most of their existing knowledge and skills, we found moving and handling training was not being refreshed at regular enough intervals.

We have downgraded the rating for this key question from 'good' to 'requires improvement' and we will review our rating at our next inspection of this service.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The provider had taken some action to improve the way they monitored the quality and safety of the service people who lived at the home received, which included closer scrutiny of staff's medication handling practices. However, their governance systems were not that effective in order to ensure continuous and sustained improvement of the service over a period of time.

The service continues to be rated 'requires improvement' in this

key question. We will review our rating for 'well-led' at our next inspection of this 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 was 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 focused inspection was carried out over two days. The first day was undertaken on 12 May 2016 by an inspector and specialist professional advisor (SPA). The SPA is a qualified nurse specialising in the prevention and management of falls for older people. The second day, which took place on 16 May 2016 and was also unannounced, was carried out by a CQC specialist pharmacy inspector.

This inspection was undertaken to check the provider had taken all the action they said they would in their improvement plan to meet legal requirements and to look specifically at how the service mitigated risks in relation to people falling. We inspected the service against three of the five questions we ask about services: Is the service safe? Is the service effective? Is the service well-led?

Prior to the inspection we looked at an assortment of information we held about the service. This included the action plan we had asked them to send us. The action plan sets out how the provider intended to meet the regulations they had breached at their last inspection. We also reviewed any notifications sent to us by the provider about significant incidents and events that occurred at the service, which the provider is required by law to send to us, and their Provider Information Return (PIR). The PIR 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 this two-day inspection we spoke with four people who lived at the home, six people's visiting relatives, two community professionals, an external trainer, the services registered manager, the area manager, a company director, the homes clinical governance lead/deputy manager, six nurses, four care workers and a business support worker. We also looked at six people's care plans, 60 medicine administration record (MAR) sheets, six staff recruitment, training and supervision files, and a wide range of other documents that related to the overall management of the home.

In the last couple of months we have also attended a number of safeguarding meetings led by the local authority in respect of Sutton Court Care Centre where we received feedback about the provider from a range of community based health and social care professionals who supported and/or represented people using the service.

Requires Improvement

Is the service safe?

Our findings

After our last inspection of this service in October 2015 we received information from various health and social care professionals who represented people using the service and/or the local authority. These professionals were concerned about the high number of serious injuries sustained by people who lived at Sutton Court Care Centre in 2016 after they had had falls at the home.

Care plans we examined all included basic risk assessments. However, staff had not always appropriately considered, identified and mitigated the risks to people's safety. The assessment process was not significantly robust to identify all the risks to people's safety. For example, we found no recorded evidence to show a manual handling risk assessments had been carried out in respect of one person who required a mobile hoist and support from staff with moving and handling. There was also no risk assessment for another person in relation to them having been identified at risk of falling.

The provider was in breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The service has experienced high levels of staff turnover in the last 12 months. We received mixed feedback from people about staff turnover and a lack of staff continuity at the home. Typical comments from people included, "So many new staff have started recently. I think it's confusing for the people who live at the home"; "The staff are lovely… It's just a shame so many of them keep leaving" and "Loads of staff have left recently...I can't keep up with all the new faces these days". We discussed staff turnover with the registered manager who confirmed that 16 members of staff had left the service in the last 12 months and 20 new staff had started in the same time period. They told us the service almost had its full complement of staff, although acknowledged it would take time for most new staff to complete their induction and familiarise themselves with people's needs and preferences. The registered manager also told us the provider had recently introduced exit interviews for staff who had decided to leave in order to help them understand why some staff no longer wanted to work at Sutton Court Care Centre.

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's relative said, "There always seems to be plenty of staff about whenever I visit my [family member]", while another told us, "There's lots of staff about today". Throughout our inspection we observed staff were visibly present in communal areas and were prompt to support people when needed. We saw numerous examples of staff attending immediately to people's requests for a drink or assistance to stand. 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 operated effective staff recruitment procedures. This was because the provider ensured appropriate pre-employment checks were carried out on all new staff before they started working at the home. Records showed these pre-employment checks included proof of staffs' 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. Managers also said they worked closely with the Home Office to ensure that right to work and identity documents obtained from staff were valid and up to date to support their employment at the service. The registered manager gave us a good example when they had done that.

People were supported by staff to take their medicines when they needed them. We observed nurses giving people their prescribed medicines in a safe and caring manner, taking time to ensure that people were comfortable to take them. Our own checks of medicines in stock confirmed medicines were available for people as prescribed to them. Staff gave us a good example of appropriate action they had taken when they found one person's prescribed medicines had been out of stock from the manufacturer. They told us the nurse in charge of the unit that day had been pro-active in arranging for the person's GP and a local pharmacist to resolve the issue. We saw medicines were stored securely in cupboards and trolleys around the home.

People had their own medicines administration record (MAR) sheets which included a photograph of them, a list of their known allergies, and information relating to dose changes or blood tests. MAR sheets were clear and all administrations were signed for or a record was made when medicines were omitted as to why they were omitted. Some people were prescribed medicines to be given 'when required' and we saw that protocols and pain assessments were available to support staff when to administer the medicines. Controlled drugs were stored and recorded appropriately and medicines requiring cold storage were stored in a separate fridge and the temperature was regularly monitored. Staff had been suitably trained to manage medicines safely. Records showed staff had received training in safe handling and administration of medicines and their competency to continue doing this safely was assessed at regular intervals.

Requires Improvement

Is the service effective?

Our findings

Staff had not been appropriately trained in some key aspects of their role. We received mixed feedback from people about the knowledge, skills and experience of staff. Typical comments included, "Most of the staff seem to know what they're doing, despite there being so many new starters", and "I'm very impressed with the attitude of all the nurses and carers that work at the home, but I think some of the newer staff will need a lot more training to fully understand what my [family member] needs and likes" and "The staff that have been here a long time generally do a good job. I guess the new staff will get better over time, the more experience and training they get".

It was clear from records we looked at and comments made by the registered manager that none of the home's staff had received any mental health or learning disability awareness training despite providing a service to a number of people with mental health needs or a learning disability. Records also indicated most staff had not refreshed their moving and handling training for over three years. The registered manager and an external trainer both agreed and told us staff would be better equipped to meet the needs of people using the service if their moving and handling competency was assessed more frequently, and staff who supported people living with mental ill health problems received specialist training in this aspect of their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The points made above notwithstanding, we saw people received care and support from staff who were on the whole appropriately trained. All new staff were required to work towards achieving the 'Care Certificate', which several new members of staff we spoke with confirmed. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Records indicated that most staff who worked at the home had completed training in dementia awareness, moving and handling, safeguarding, positive behavioural support, equality and diversity, basic life support, health and safety, prevention and control of infection, dignity and respect, fire safety, malnutrition and assistance with eating, end of life care and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Staff spoke positively about the training they had received. Staff told us their training was always on-going and relevant to their role. One member of staff said, "My induction was very thorough", while another member of staff told us, "I think the training we get here has got a lot better recently and there is certainly more of it these days".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2015 we found the governance systems the provider had established to monitor the quality of the care people using the service received were not always operated effectively. Specifically, the provider's quality monitoring systems had failed to identify a number of omissions on medication administration records (MARs) where staff had not signed for medicines they had administered, as well as noticed vital information such as employment references were not always included in staff files.

At this focused inspection we found the provider had taken appropriate steps to follow the action plan they had sent us and improve the way they monitored staffs medicines handling practices and pre-employment checks undertaken in respect of new members of staff. For example, nurses described how they checked MAR sheets when they were giving medicines to make sure there were no omissions. Records indicated controlled drugs were checked daily, which nurses we talked with confirmed. It was also clear from records we looked at and comments we received from office based staff that staff files were now being audited at regular intervals to check the information they contained was up to date and accurate. The registered manager gave us a good example of how routine audits of staff files helped them identify when staffs eligibility to continue working in the UK was about to expire which enabled the provider to take appropriate and timely action and make a referral to the relevant agency.

During this inspection we found the provider had taken further action to improve their governance systems. Records showed managers and senior staff now routinely carried out audits at the home which included reviewing staff's adherence to policies and procedures, and speaking with people using the service and their relatives to obtain their feedback about the home. We also saw the registered manager had developed a time specific action plan in response to recommendations made by an external auditor who had recently reviewed all the home's health and safety arrangements.

However, whilst we saw the provider had made some progress to improve the effectiveness of their quality monitoring arrangements, further action is required. For example, despite the registered manager introducing monthly care plans reviews we found no recorded evidence to show four care plans we looked at had been reviewed and updated accordingly since February 2016. We also saw that the current systems to review the quality of care records were not robust enough to identify the concerns we found in regards to identifying and mitigating risks to people's safety. The provider had also not identified the training needs of staff in relation to caring for people with mental health needs or with a learning disability and refreshing manual handling training for staff as required.

The provider remained in breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that people were protected from unsafe care and treatment as they had not sufficiently identified and mitigated the risks to people's safety. Regulation 12 (1) (2) (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 People using the service were at risk of not always having their needs fully met because staff had not received all the appropriate training they required to enable them to carry out the duties they are employed to perform safely and to a relevant standard. Regulation 18(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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that sufficient systems were in place to monitor and improve the quality of the service, and to ensure risks to people were identified and mitigated. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014