Habilis Operations Limited

Sutton Lodge Nursing and Residential Home

Inspection report

Station Road
Sutton-On-Sea
Mablethorpe
Lincolnshire
LN12 2HR
Tel: 01507 441905

Date of inspection visit: 28 April 2015
Date of publication: 22/07/2015

Ratings

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

Overall summary

The service provides care and support for up to 34 people. When we undertook our inspection there were 11 people living at the service.

We inspected Sutton Lodge Nursing and Residential Home on 28 April 2015. This was an unannounced inspection. Our last inspection took place on 12 June 2014.

The people in the home were mainly older people. They had mixed abilities to look after themselves. Some required help to walk. A couple of people preferred to remain in their bedrooms and not to socialise. The home looked after people in varying stages of dementia. There were no people who currently required nursing care.

Summary of findings

Medicines were stored safely, but parts of the storage area was unclean and other equipment was stored in this area. Staff had not maintained accurate records of when medicines had been given and received by the pharmacy.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives. However, there was no method of assessing the dependency of people and ensuring sufficient staff were on duty to meet people's needs.

People had been consulted about the development of the home but no quality checks had been completed to ensure the quality of services was being maintained.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the number of staff available at times, the storage and record keeping of medicines and not monitoring the quality of the service. You can see what action we told the provider to take at the back of the full version of the report.

There was no registered manager in post. The registered manager of a sister home was overseeing the running of this home as well. The home had been without a registered manager since December 2014. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. There were no DoLS authorisations in place at this time.

The people living at the home were elderly. Some were mobile and could walk around easily, whilst others required walking aids or wheelchairs. Some people were ill and were being nursed in their beds.

People's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness, compassion and respect. Staff took time to speak with the people they were supporting.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. People were not supported to develop their own interests and hobbies.

The provider used safe systems when new staff were recruited. All new staff completed thorough training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual. Staff had not received supervision to ensure they could do their jobs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Checks were made to ensure the environment was a safe place to live.

Insufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were not stored and administered safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training to enable them to do their job. Staff had not received supervision to ensure they could do their jobs.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Requires improvement

Is the service caring?
The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Good

Is the service responsive?
The service was responsive.

People's care was planned and reviewed on a regular basis with them.

People knew how to make concerns known and felt assured anything would be investigated in a confidential manner.

Staff ensured other health and social care professionals were aware of people's needs when they moved between services.

Good

Is the service well-led?
The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Requires improvement

Summary of findings

No checks were made to ensure the quality of the service was being maintained.

People's opinions were sought on the services provided and they felt those opinions were valued.

Staff knew where to go for advice about the running of the home.

Sutton Lodge Nursing and Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 28 April 2015 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider both before and during the inspection. This was in order to obtain their view on the quality of care provided by the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection, we spoke with five people who lived at the service, two relatives, five members of the care staff, two domestic staff members, a cook and the company who ran the service. We also observed how care and support was provided to people.

We looked at four people's care plan records and other records related to the running of and the quality of the service. These included staff rotas, training records of staff, accident records, complaints documentation and service details of equipment in use.

Requires improvement

Is the service safe?

Our findings

People told us their needs were being met. However, one person said, "There's lots of economies here." Two relatives told us they felt abandoned as some staff had recently left suddenly and the staffing numbers now were lower.

Staff said there were not always sufficient numbers of staff to enable them to meet people's needs. One staff member said, "We've been told we are down to minimum staffing levels at the moment." Another staff member said, "We are managing at the moment." Staff told us that due to the low occupancy and staff leaving the shifts were busy and on new rotas staffing levels, particularly in the domestic and kitchen departments had been reduced. The rotas confirmed that staffing levels were being changed the week after our visit. We were told this was because the occupancy in the home would be reduced and the dependency of people was lower. No explanation was given of why this was to take place and the decision process to ensure people's needs were going to be met. There was no method in place to determine the dependency of people using the service. Therefore, staffing levels could not be accurately decided.

We observed staff were busy throughout the day but did attend to people's needs. Sometimes people had to wait. They explained to people if they had to wait for care needs to be met. People accepted the staff reasons. However, one person said, "It's always happening recently." Calls bells were heard but not answered promptly. We had to ask a staff member to attend to a person's needs who had been calling out and ringing their bell for over 10 minutes.

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

Medicines were kept in a safe environment. However, there were a lot of items, not related to medicines, stored in the room. Staff told us this made it difficult to keep clean. The floor was unclean but storage shelves were clean. Containers of needles and syringes were waiting to be disposed of and staff had failed to contact the waste disposal company to remove them.

We looked at nine people's medicine records and six had not been completed correctly. Some medicines received from the pharmacy two days before, were still to be checked into the home. Entries in one record book showed medicines should still be in the home even though people had moved to another home. It was later confirmed the new home had received those medicines. Staff had not completed their own records, in this home, correctly. This meant we could not be sure whether people had received their medicines.

We observed medicines being administered and noted appropriate checks were carried out and the administration records were completed. However, the staff member was disturbed during the administration process by visitors and other staff. This made it difficult for the staff member to concentrate on giving the medicines safely.

Staff who administered medicines had received training on administering medicines safely. We saw this had taken place in April 2015. Internal medicine audits had not been carried out since December 2015.The local pharmacy had completed an audit in April 2015. Recommendations they had made and not been completed. All of these checks would ensure that people were kept safe and protected by the safe administration of medicines if actions had been followed up.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. One person said, "I do feel safer here than at home." Another person said, "I'm safe as I can be here with the staff."

Seven of the staff told us they had received training in how to look after vulnerable people and recognise abuse. The other two did not know when the next training session had been planned. This was confirmed in staff training records. They were able to explain what constituted abuse and how to report incidents should they occur. They did not know the processes which were followed by other agencies but told us they felt confident the senior staff would take the right route to safeguard people. A lack of training of staff and knowledge of how to report concerns could put people at risk if staff do not know what to do.

To ensure people's safety was maintained a number of risk assessments were completed for each person and people had been supported to take risks. For example, where people required bedrails on their beds to prevent them falling. Assessments had been made on the risk of using them and the decisions recorded. Where people were at risk of not maintaining an adequate diet because their loss

Requires improvement

Is the service safe?

of memory meant they did not remember eating, instructions were in place for staff to monitor each person's diet and weight. Where necessary staff had involved other health professionals for advice on suitable diets.

When an incident or accident happened in the home the provider let the Care Quality Commission (CQC) know. They made appropriate referrals, when necessary, if they felt events needed to be escalated to the safeguarding adults team at the local authority. This ensured people were protected against harm coming to them.

Plans were in place for each person in the event of an evacuation of the building. The assessments included how people might respond when knowing there was a fire in the building and if people required one or two staff to help them evacuate the building. This ensured people could leave the building quickly in the event of a fire. However, the business continuity plan which identified to staff what they should do if utilities and other equipment failed had not been updated since February 2011.

Fire equipment had been serviced at the beginning of April 2015. Fire checks had been completed up to December 2014 but not since. We saw that some fire doors were not closing correctly, so would not be an effective barrier in the event of a fire. Staff knew what to do in the event of a fire and direction notices were in place. A failure to maintain fire protection could result in harm to people in the event of a fire.

We looked at five staff files which showed security checks had been made prior to their commencement of employment to ensure they were safe to work with people. These included information on their past career history, qualifications and references from other employers and character references. Safety checks had been made with the disclosure and barring service, which check staff are suitable to work in this environment. These measures helped to ensure only suitable staff were employed.

Requires improvement

Is the service effective?

Our findings

People told us they were happy living at the home. They told us they liked the staff and said if they required to see a doctor or nurse staff would respond immediately.

People's health needs were being looked after. Relatives told us they were aware district nurses visited their family members. They said they were involved in discussions when their family member asked them. The provider was changing the type of services they were providing and the commissioners of those services from the local authority and NHS had reassessed each person's needs. People using the service and relatives were aware of recent reassessments of people's needs. They knew this had been necessary due to changes being made.

We observed staff writing about discussions with other health and social care professionals in people's care plans. The staff were liaising with the district nursing service to ensure they were following specific guidance to help people maintain their health and wellbeing. The staff gave an overview of each person's immediate needs and had information to hand about the person when speaking with other health care professionals.

We observed staff handing over between shifts. They ensured the staff coming on duty were aware of everyone's needs and what treatments were left to complete. Staff were given the opportunity to ask questions. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten.

One staff member told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as manual handling and bathing people. They told us it had been suitable for their needs. We saw the induction records within the person's personal file. This had ensured the person was capable of completing their job role before being offered a permanent post.

Staff said they had completed training in topics such as manual handling, fire and first aid. They told us training was always on offer. The training records supported their comments. Some staff had received training in specialist topics such as dementia awareness and had undertaken national award schemes in care. They said this helped them understand the needs of people better. There were posters on display giving staff details of training opportunities in manual handling and first aid. However, there were no methods in place to test the competence of staff after training.

Staff told us that they had not received regular supervision sessions since December 2014. This would monitor their performance. No written evidence could be produced to support the last time staff had received supervision. This increased the risk of staff not working correctly.

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

We discussed this with the staff. They showed that they were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. Only five staff could remember receiving training in the Mental Capacity Act 2005. The training records did not show how many staff had received that training. Staff did know how to care for someone who could not make decisions for themselves.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. There was no-one subject to any DoLS authorisation at the time of our visit.

People told us that the food was good, which was echoed by relatives. One person said, "The food's good. I like most meals, we always get a choice." Another person said, "The food is always good quality." We saw the lunchtime meal in the dining room. The meals were presented well and looked very appetising. Staff spoke quietly with people who required assistance to eat their meal. They gave gentle encouragement and explained what was available as alternatives if they did not like the meal offered. People were offered hot and cold drinks throughout the day, as

Requires improvement

Is the service effective?

well as visitors. We saw one person asking for some fresh fruit which was given. Staff explained these were kept in the kitchen as some people did not like others touching their food.

The staff we talked with knew which people were following special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their diabetes with their diet and when a person required a softer diet. We saw staff had asked for the assistance of the hospital dietary team in planning people's dietary needs. Staff told us each person's dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and kind. All were full of praise for the staff. One person said, "Staff are polite and kind." Another person said, "The staff are wonderful. [Named staff member] is lovely." Relatives told us their family members were happy in the home and they trusted the staff.

Staff were all caring and kind towards people. They were patient with people when they were attending to their needs. We observed staff ensuring people understood what care and treatment was going to be delivered before commencing a task, such as helping someone to walk from one room to another and giving medicines.

Staff described the actions they took to preserve people's privacy and dignity. They said they would knock on their bedroom doors before entering and closing doors and curtains when providing care. We observed staff knocking on doors before entering a room. Staff spoke quietly to people and were unhurried in their approach, always giving time for people to respond to questions and walking with them at the person's own pace.

We observed many positive actions and saw that these supported people's well-being. Many people appeared to enjoy a banter with staff and were laughing and joking. We saw one staff member discussing the television programme they were watching. People were interested in what was going on during the day in the home. People who could not make decisions for themselves were engaged in positive tasks such as combing their hair, watching other people and engaging in the television programme by singing the appropriate songs.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, one person wanted to spend most of the day in their bedroom and staff helped them when they wanted to use a toilet.

Relatives we spoke with said they were able to visit their family member when they wanted. They said there was no restriction on the times they could visit the home. One person said, "We support staff in what they try to do. [Named relative] is happy here because they tell me and I can visit any time."

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Details of the local advocacy service were on display.

People had access to several sitting room areas, a dining room, a conservatory, quiet areas in corridors and a garden. We observed staff asking people where they would like to be if they required assistance to move about the building. Staff ensured each person was comfortable, they had a call bell to hand and had all they required for a while. This was sometimes a newspaper or watching the television. Other people we observed walked or used a wheelchair to access various parts of the home and grounds. One person said, "I'm very comfortable in my room."

Good

Is the service responsive?

Our findings

The people we spoke with told us staff responded to their needs as quickly as they could. One person said, “They keep me up to date.” Another person said, “The staff look after my needs beautifully.”

People told us staff talked with them all the time. We observed staff interacting with people and getting assistance when required, such as, when a person required two staff members to move them in the bed.

Staff responded quickly when people said they had physical pain or discomfort. When someone said they had a stomach ache, staff gently asked questions and the person was taken to one side and given some medication.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, we observed staff using moving equipment appropriately and asking people whether they felt it was the most effective way of moving them.

Health and social care professionals we spoke with before and during the inspection told us they knew staff were giving person centred care. They said improvements in what staff knew was still required in some topics but commissioners of the service had helped staff to link with other agencies. Staff confirmed they had developed links with infection control nurses, dieticians and physiotherapists.

People told us they could get up and go to bed when they wanted. They said there was always an opportunity to join in group events but staff would respect their wishes if they wanted to stay in their bedrooms. People told us about the bingo sessions and entertainers. We saw jigsaws, books on various topics and music cassettes in the sitting rooms.

Staff told us how they would respond to people’s cultural and religious needs. They knew the local resources to use and there were leaflets on display of local associations. Theses included groups for relatives whose family members lived with dementia and the local Age UK meetings. However, the activities described by people were group centred such as bingo and entertainers. We did not find any one who had been encouraged to develop their own interests and hobbies. One person told us they would like to knit and another had interests in bird watching which had not been encouraged. Any activities people had taken part in were documented. When we were invited to visit people’s rooms they had been personalised to suit their tastes and needs.

People told us they were happy to make a complaint if necessary and felt their views would be respected. No-one had made a formal complaint since their admission. People knew the names of all the staff and those of the owners and told us they felt any complaint would be thoroughly investigated. We saw the complaints procedure on display, which was in English. However, they did not have access to the information in different formats. This could mean people with a visual impairment for example may not be able to access that information. The provider told us they would rectify this.

Requires improvement

Is the service well-led?

Our findings

There was no evidence to show the provider had completed audits to test the quality of the service. We were told all the audits had disappeared and the provider did not know where they were. The provider told us they were not aware how the quality assurance system worked at this home. A failure to test the quality of the service being provided could result in the needs of people not being met.

Areas of the home had been redecorated and some furniture had been purchased. However, several areas of the home, such as, a sitting room, the conservatory, the gardens and bathrooms still required to be refurbished. There was a plan in place to purchase new carpets and furniture and complete the work but no times scales.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The care plans had not been updated and advice from other health professionals about keeping care plans up to date had not been actioned. The staff understood their responsibilities and knew of other resources within the company they could go to for advice, but had only just started using thise resources.

There had been no clear leadership in the home for five months. There had been several changes in senior staff and a manager. Staff told us this had been an unsettling period. The home was currently being overseen by the registered manager of a sister home.

Records in the home were disorganised. Staff took a long time to find necessary information to ensure people's needs were being met and they could pass on queries to other health professionals. Staff were unaware of where records such as supervision logs of staff and charts for monitoring people's weights were kept. Information from other agencies audits such as the pharmacy audit had not been actioned.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had been disappointed in the recent management within the home. They told us they were well looked after, could express their views to the staff and felt their opinions were valued. One person said, "We know things need to improve, but I'm fine at the moment." Another person said, "I have nice chats with people."

We saw questionnaires people had completed. Staff said this was recently sent out but the questionnaires we saw were not dated. They had asked for people's views about personal care of individuals, daily living and activities.

Relatives told us if they had any problems they could go to the staff. One relative said, "Great, very supportive." However, they had been very disappointed with staff leaving and how the service could no longer receive nursing clients.

People who used the service and relatives told us they did not see the point of residents meetings when they could see the staff each day. We saw in the care plans people's comments about the services being provided had been recorded. There was no evidence to show any actions taken had been reviewed.

The home had very recently undergone a review of the type of services it could provide. A lot of input had been given by the local commissioning teams and staff told us they had been grateful for their input. Staff said they now knew who to ask advice from and were seen doing so during the day. We saw staff telephoning their new contacts for advice as people's needs changed through

out the day.

Staff told us they were developing more as a team. One staff member said, "It's been a hard couple of weeks, but I think we have a dedicated workforce now." Another staff member said, "We can voice opinions but I don't know if they are valued." Staff told us they were frustrated when things did not get done. For example, ensuring the equipment was in working order, completing maintenance tasks and tidying the garden.

There was no registered manager at the home. The registered manager at a sister home within the company had been asked by the provider to cover both homes. The registered manager told us how they intended covering some aspects of the home's delivery of care. This was only looking at care plans, ensuring policies were in place and

Requires improvement

Is the service well-led?

recruiting new staff. The provider was temporarily managing other aspects of running the home and considering how to manage this and another home within the group of homes.

Staff told us staff meetings used to be held monthly but they had not had so many since December 2015.They records confirmed their statements.They said the meetings had been used to keep them informed of the plans for the home and new ways of working. They said they hoped they would be restored as the meetings had enabled them to voice their opinions. Staff had not been given opportunity to voice their opinions.

All the staff we spoke with told us they felt people were well cared for in this home. They said they would challenge their colleagues if they observed any poor practice. One staff member said, “We all keep an eye on the residents and I think they would tell us if things were wrong.” Staff told us of an incident which had occurred and felt their opinions had been valued in ensuring the whistle blowing process had been implemented.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were no methods of assessing the dependency of people who used the service and insufficient staff on duty. Regulation 18 (1)**

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 storage and stock control of medicines was not being maintained and recording of medicines taken was poor. Regulation 12 (2) (g)**

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 **There were no systems in place to ensure the quality of the service was being maintained. Regulation 17 (2) (a)**